

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME  
5M 1/62

MONTGOMERY STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
02432 02389											
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. <del>NAME OF PLACE OF DEATH</del> (If not in hospital, give street address) <b>Brooke Road</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Brinklow</b> d. STREET ADDRESS <b>Brooke Road</b>					
3. NAME OF DECEASED (Type or print) <b>Corrinne Isabel Addison</b>						4. DATE OF DEATH Month <b>2</b> - Day <b>6</b> Year <b>1966</b>					
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 3, 1912</b>		9. AGE (In years birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>15</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) <b>Brinklow, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Louis Powell</b>						14. MOTHER'S MAIDEN NAME <b>Redmond, Edna (Eddie) Jerushia</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>Detective Cpl. James H. Glazier</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Charring burns, 100% of body, incurred in</b> <b>9160</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>house trailer fire.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased incinerated in house trailer fire.</b>							
20c. TIME OF INJURY Month, Day, Year <b>3:00</b> p.m. <b>2/6/66</b> 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>House trailer</b>		20f. (City or town) <b>Brinklow</b> (County) <b>Montg.</b> (State) <b>Md.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Belden R. Reap</b> EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Feb. 7, 1966.</b> Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, or other disposal (Specify)				22b. DATE THEREOF <b>2/11/66</b>		22c. NAME OF CHURCH OR CREMATORY <b>Ash Memorial</b>		22d. LOCATION (City, town, or county) <b>Sandy Spring, Md.</b> (State)			
23. FUNERAL DIRECTOR <b>Robert L. Snowden</b>						ADDRESS <b>Rockville, Md.</b>		24a. REC'D BY REGISTRAR <b>FEB 11 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1. *Chrysomelidae* (1000)  
 2. *Curculionidae* (1000)  
 3. *Chrysomelidae* (1000)  
 4. *Curculionidae* (1000)  
 5. *Chrysomelidae* (1000)  
 6. *Curculionidae* (1000)  
 7. *Chrysomelidae* (1000)  
 8. *Curculionidae* (1000)  
 9. *Chrysomelidae* (1000)  
 10. *Curculionidae* (1000)

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02433

CERTIFICATE OF DEATH

02390

Item #23b Film #5373 2/23/66 pc

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY in lb <b>41 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arlington</b> <b>83-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>1900 Columbia Pike Apt. 416</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Irma</b> Middle <b>Louise</b> Last <b>ALBRECHT</b>			4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Aug. 2 1909</b>		9. AGE (In years last birthday) yrs. <b>56</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>G. H. Beck</b>			14. MOTHER'S MAIDEN NAME <b>Louise Duesing</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>537-42-4534</b>	17. INFORMANT <b>Apt. Address 416, Arlington, Va. Capt. Herbert C. Albrecht 1900 Columbia Pike</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the colon with metastases</b> <b>1538</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that <del>(this hospital)</del> attended the deceased from <b>Jan. 3</b> , 19 <b>66</b> , to <b>Feb. 14</b> , 19 <b>66</b> , that <del>(I)</del> (we) last saw the deceased alive on <b>Feb. 14</b> , 19 <b>66</b> , and that death occurred at <b>155P</b> M, from causes and on the date stated above.					
22a. SIGNATURE <b>P. B. Blanchard, M.D.</b>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb. 15, 1966</b>
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Feb. 18, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>		
24. FUNERAL DIRECTOR <b>Ives Funeral Home</b> ADDRESS <b>2847 Wilson Blvd. Arlington, Virginia</b>			25a. REC'D BY REGISTRAR <b>FEB 17 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)  
15M 4-64

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(M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02434 CERTIFICATE OF DEATH 02391

1. PLACE OF DEATH a. COUNTY <u>Montgomery City</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> c. LENGTH OF STAY IN ID d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Potomac Valley Nursing Home</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Gordon</u> Middle <u>H.</u> Last <u>Allen</u>		4. DATE OF DEATH Month <u>February</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <u>July 31, 1904</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Small Business Administrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Government</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Indiana</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>056-03-4170</u>	17. INFORMANT Address <u>Hospital Records</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bilateral Pneumonia</u> 148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>bercunome of the Pharynx, extensive</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>October</u> , 19 <u>65</u> , to <u>Feb 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>February 18</u> , 19 <u>66</u> , and that death occurred at <u>12:25 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>DE Flores.</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>2/18/66</u>
22c. PHYSICIAN'S NAME (Type) <u>Dino E Flores</u>		22d. ADDRESS <u>50 W. Edmonston Dr. Rockville, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>	25a. REC'D BY REGISTRAR <u>FEB 23 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02435

02392

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>2 months 25 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> 15-1 d. STREET ADDRESS <u>10 Sherman Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First Middle Last <u>Mary Eugenia Ambrosi</u></p>		<p>4. DATE OF DEATH Month Day Year <u>February 4 19 66</u></p>		<p>5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>			
<p>8. DATE OF BIRTH <u>7-4-96</u> 9. AGE (in years last birthday) <u>69</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. <u>19 66</u></p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired school teacher</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Retired school teacher</u></p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Manassas W. VA</u> 12. CITIZEN OF WHAT COUNTRY? <u>United States</u></p>			
<p>13. FATHER'S NAME <u>William Moore Lowman</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Clara ?</u></p>		<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>no</u> 17. INFORMANT <u>Hospital Records</u> Address</p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Silent. Pulv. Embolism</u> 352X DUE TO (b) <u>Thrombosis, femoral vein rt.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>RT Hemiplegia</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Ch. Reg. Myocardium coronary thrombosis with Stent Block.</u></p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> 11/27/65</p>							
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ch. Reg. Myocardium coronary thrombosis with Stent Block.</u></p>							
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED White at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>741</u></p>			
<p>20f. (City or town) <u>Washington</u> (County) <u>DC</u> (State) <u>DC</u></p>		<p>21. I certify that (if (this hospital) attended the deceased from <u>2/3</u>, 19<u>66</u>, to <u>2/4</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2/3</u>, 19<u>66</u>, and that death occurred at <u>6:30</u> M, from the causes and on the date stated above.</p>					
<p>22a. SIGNATURE <u>Howard T. Morse</u></p>		<p>22b. DATE SIGNED <u>2/4/66</u></p>		<p>22c. PHYSICIAN'S NAME (Type or print) <u>Howard T. Morse</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>			
<p>22d. ADDRESS <u>1030 Carroll Ave Takoma Park, Md</u></p>		<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>TEMP BURIAL</u> 23b. DATE THEREOF <u>Feb. 9, 1966</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Mausoleum</u> 23d. LOCATION (City, town or county) (State) <u>Colmar Manor P.A. Co. Md</u></p>					
<p>24. FUNERAL DIRECTOR <u>Arthur Walters</u> ADDRESS <u>254 Carroll St. N.W. Washington, D.C. 20012</u></p>		<p>25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>					

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02436

## CERTIFICATE OF DEATH

02393

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
c. LENGTH OF STAY IN 1b. <u>1 day 5 hrs.</u>		d. STREET ADDRESS <u>75 Adams Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Edna</u> Middle <u>Martha</u> Last <u>Anders</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/29/92</u> 73 yrs.
9. AGE (In years last birthday) <u>73</u>		10. IF UNDER 1 YEAR Months <u>4</u> Days <u>14</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arthur Fairfax Thomas</u>		14. MOTHER'S MAIDEN NAME <u>Mary W. Bladen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Edna M. Edwards</u>		Address <u>Same as above</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic glomerulonephritis</u> DUE TO (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> Years <u></u>	
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Coronary arteriosclerosis with thrombosis, right coronary artery</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 2-12, 1966, to 2-13, 1966, that (I) (we) last saw the deceased alive on 2-13, 1966, and that death occurred at 8 PM, from causes and on the date stated above.

22a. SIGNATURE <u>W.G. Hall</u> M.D.	22b. DATE SIGNED <u>2-13-66</u>
22c. PHYSICIAN'S NAME (Type) <u>W.G. Hall, M.D.</u>	22d. ADDRESS <u>615 W. Montgomery Ave., Rockville</u>

23a. BURIAL, CREMATION, or other disposition (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville, Md.</u>
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24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> ADDRESS <u>Bethesda, Md.</u>	25a. REC'D BY REGISTRAR <u>FEB 17 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

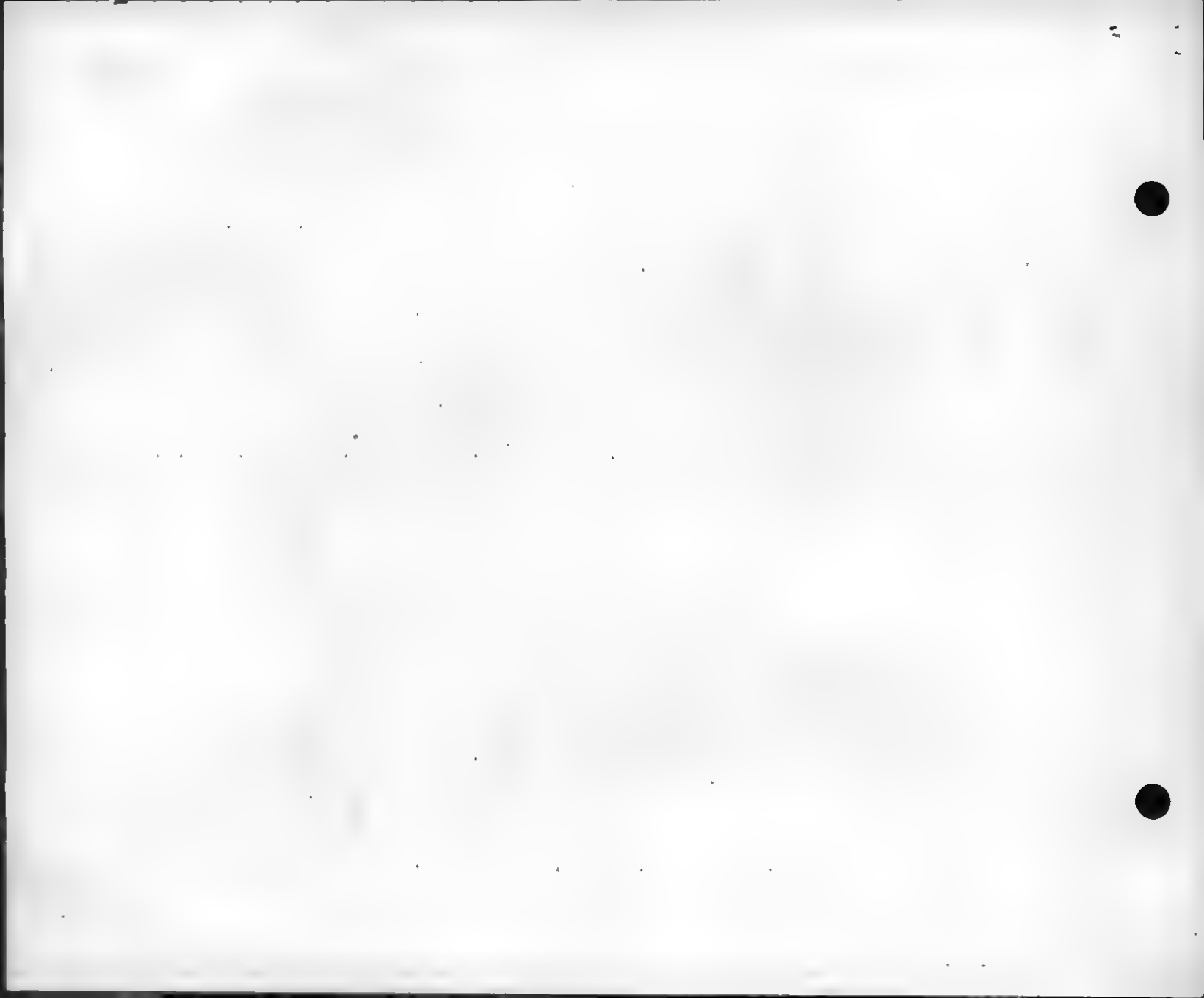
## CERTIFICATE OF DEATH

02437

02594

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (Rural)</b>			c. LENGTH OF STAY IN 1b <b>30 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>5330 Belt Road, N. W.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3 NAME OF DECEASED (Type or print) First Middle Last <b>Ada Lenore Angel</b>				4. DATE OF DEATH Month Day Year <b>February 17 19 66</b>				
5 SEX <b>Female</b>		6 COLOR OR RACE <b>Cauc</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8 DATE OF BIRTH <b>April 8, 1876</b>		
9 AGE (In years last birthday) <b>89</b> yrs		IF UNDER 1 YEAR Months Days Hours Min <b>10 9</b>		IF UNDER 24 HRS Hours Min <b>10 9</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of workng life, even retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (County & State, or foreign country) <b>Carlinville, Illinois</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lemuel Sells</b>				14. MOTHER'S MAIDEN NAME <b>Mary Ann Moore</b>				
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16 SOCIAL SECURITY NO. <b>556-14-2427</b>		17. INFORMANT <b>Daug.</b> <b>Mrs. Dorothy A. Drexler, Ave. N.W. Washington D.C.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY <b>1201</b> IMMEDIATE CAUSE (a) <b>Acute myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>it</del> (this hospital) attended the deceased from <b>Jan. 18</b> , 19 <b>66</b> , to <b>Feb. 17</b> , 19 <b>66</b> , that <del>it</del> (we) last saw the deceased alive on <b>Feb. 17</b> , 19 <b>66</b> , and that death occurred at <b>1253 M.</b> from causes and on the date stated above.								
22a. SIGNATURE <b>John B. Emery, Jr.</b>			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb. 17, 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>John B. Emery, Jr., M.D.</b>			22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Suitland Md.</b>		
24 FUNERAL DIRECTOR <b>F. A. Pumphrey, 7557 Wisconsin Ave., Bethesda</b>				25a. REC'D BY REGISTRAR <b>Feb 21 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



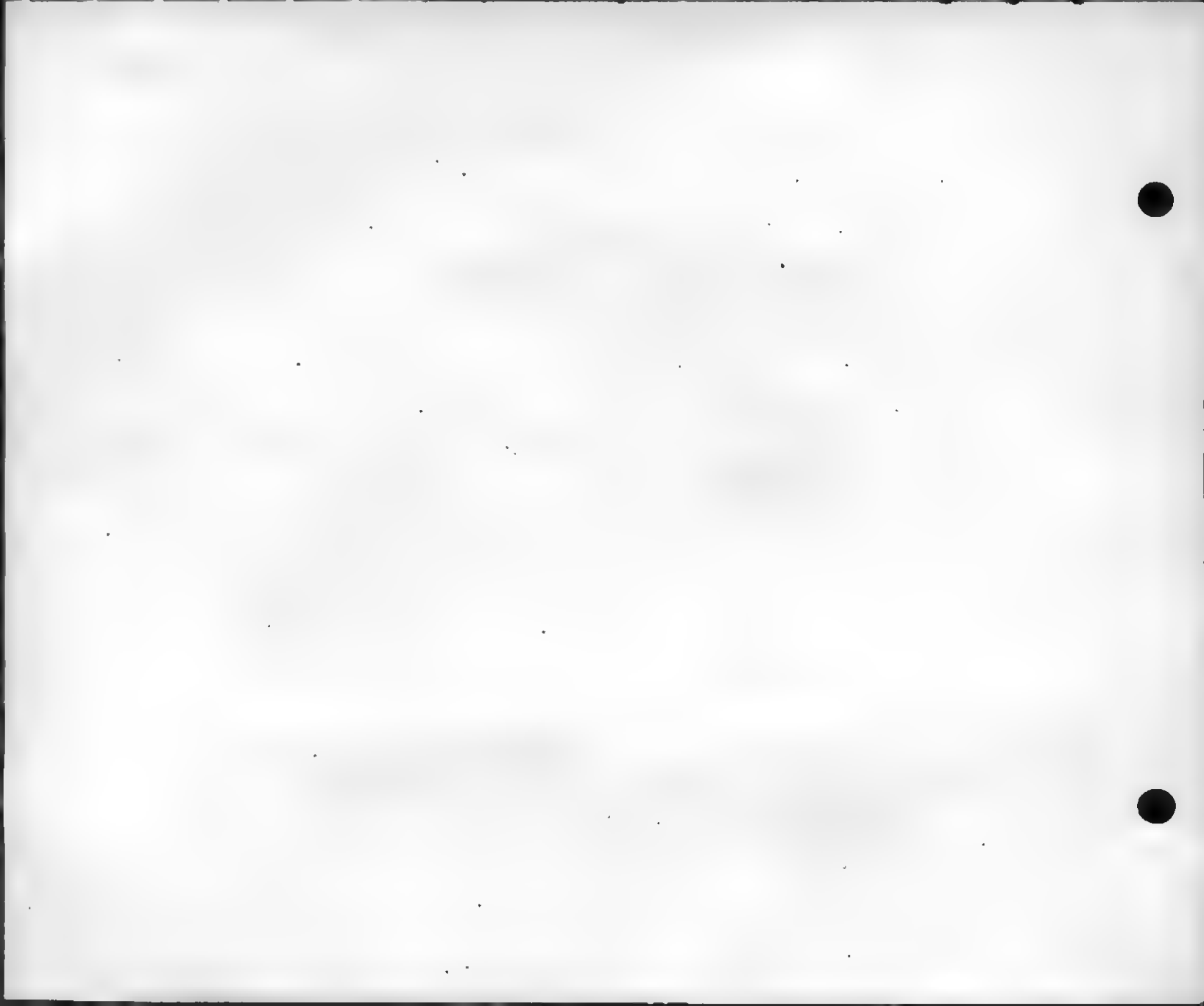
TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park</u>		c. LENGTH OF STAY IN ID <u>years</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Montgomery</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Jakoma Park Md.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>7905 Holstein Ave -</u>						d. STREET ADDRESS <u>7905 Holstein Ave.</u>			8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>ADRIAN</u>		First		Middle		Last		4. DATE OF DEATH <u>Feb. 1 - 1966</u>		Month	
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 22 - 1882</u>		9. AGE (in years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Eng. Turner (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>ILLINOIS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Martha Ann E. Payton</u>		14. MOTHER'S MAIDEN NAME <u>Martha Ann E. Payton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578-44-2064</u>		17. INFORMANT <u>MRS ESTHER ARKEBAUER</u>		Address <u>7905 Holstein Ave. Jakoma</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> <u>1810</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced Cancer bladder</u> (c) <u>Operated 2 1/2 yrs ago (inoperable)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs ±</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>To be performed at N.W.U. Hosp.?</u>							
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Off by phone from Beldon Road, Md</u>		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Med. Exam. 1966</u> to <u>1966</u> , that (I) (we) last saw the deceased alive on <u>Med. Exam. 1966</u> and that death occurred at <u>1966</u> from the causes and on the date stated above.		22a. SIGNATURE <u>Read N. Calvert</u>	
22c. PHYSICIAN'S NAME (Type) <u>READ N. CALVERT</u>		22d. ADDRESS <u>909 Pershing Drive, Silver Spring Md.</u>		22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. DATE SIGNED <u>2-1-66</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>RESEARCH</u>		23b. DATE THEREOF <u>2/2/1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GEO. WASHINGTON UNIV. MED SCHOOL</u>		23d. LOCATION (City, town or county) (State) <u>1335 H. ST. N.W. WASH. DC.</u>		24. FUNERAL DIRECTOR <u>Jakoma Funeral Home Inc. 254 Carroll St. N.W. Wash, D.C.</u>		25a. REC'D BY REGISTRAR <u>DATE B 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>		25c. REGISTRAR'S SIGNATURE	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the **final** certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02296  
32433  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery County -</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kensington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>		c. LENGTH OF STAY IN 1b <u>4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON Gardens Nursing Home</u>				d. STREET ADDRESS <u>11518 Lovejoy St. Kensington Md</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>HARVEY</u> Middle <u>JAMES</u> Last <u>BAKIER</u>				4. DATE OF DEATH Month <u>February</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 15 1879</u>	
9. AGE (In years last birthday) <u>86 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter - Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED Railroad</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Jacksonville, Illinois</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME <u>WILLIAM BAKIER</u>			
14. MOTHER'S MAIDEN NAME <u>ANNA CARRIE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>708-1298-39</u>				17. INFORMANT Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Branch pneumonia</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> <u>24 hrs</u>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1965</u> to <u>Feb 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 20, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert T. Thibadeau</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>ROBERT T. THIBADEAU</u>	
22d. ADDRESS <u>3920 FARRAGUT AVE KENS MD</u>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>2-21-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>- - -</u>		23d. LOCATION (City, town or county) (State) <u>Jacksonville, Ill</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers, papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02440

02397

<p>1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>1 hr 45 m</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington DC</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1</u> d. STREET ADDRESS <u>2420 Rochelle Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Girl</u> Last <u>Balch</u></p>				<p>4. DATE OF DEATH Month <u>February</u> Day <u>3</u> Year <u>1966</u></p>			
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>Caucas.</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>Feb. 2, 1966</u></p>	
<p>9. AGE (In years last birthday) yrs. <u>1</u> Months <u>1</u> Days <u>45</u></p>		<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country) <u>Montgomery Co., Maryland</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>				<p>13. FATHER'S NAME <u>Kenneth Balch</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Joyce Kube</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)</p>			
<p>16. SOCIAL SECURITY NO. <u>none</u></p>				<p>17. INFORMANT Address <u>mother</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>750 X</u> DUE TO <u>Intracranial hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Intracranial hemorrhage</u> (c)</p>							
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>							
<p>19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>							
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED while at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>			
<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>				<p>20f. (City or town) (County) (State)</p>			
<p>21. I certify that (I) (this hospital) attended the deceased from <u>2-2</u>, 19<u>66</u>, to <u>2-3</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>2-3</u>, 19<u>66</u>, and that death occurred at <u>1:15</u> M, from the causes and on the date stated above.</p>							
<p>22a. SIGNATURE <u>Alan W. Winchel</u></p>				<p>22b. DATE SIGNED <u>2-4-66</u></p>			
<p>22c. PHYSICIAN'S NAME (Type) <u>ALAN W WINCHEL MD</u></p>				<p>22d. ADDRESS <u>800 PERSHING DR. SS, MD</u></p>			
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>		<p>23b. DATE THEREOF <u>2/7/66</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Silver Spring, Md.</u></p>	
<p>24. FUNERAL DIRECTOR <u>Tyson Wheeler 1331 Rockville Pike, Rock. Md.</u></p>				<p>25a. REC'D BY REGISTRAR <u>FEB 10 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>			

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

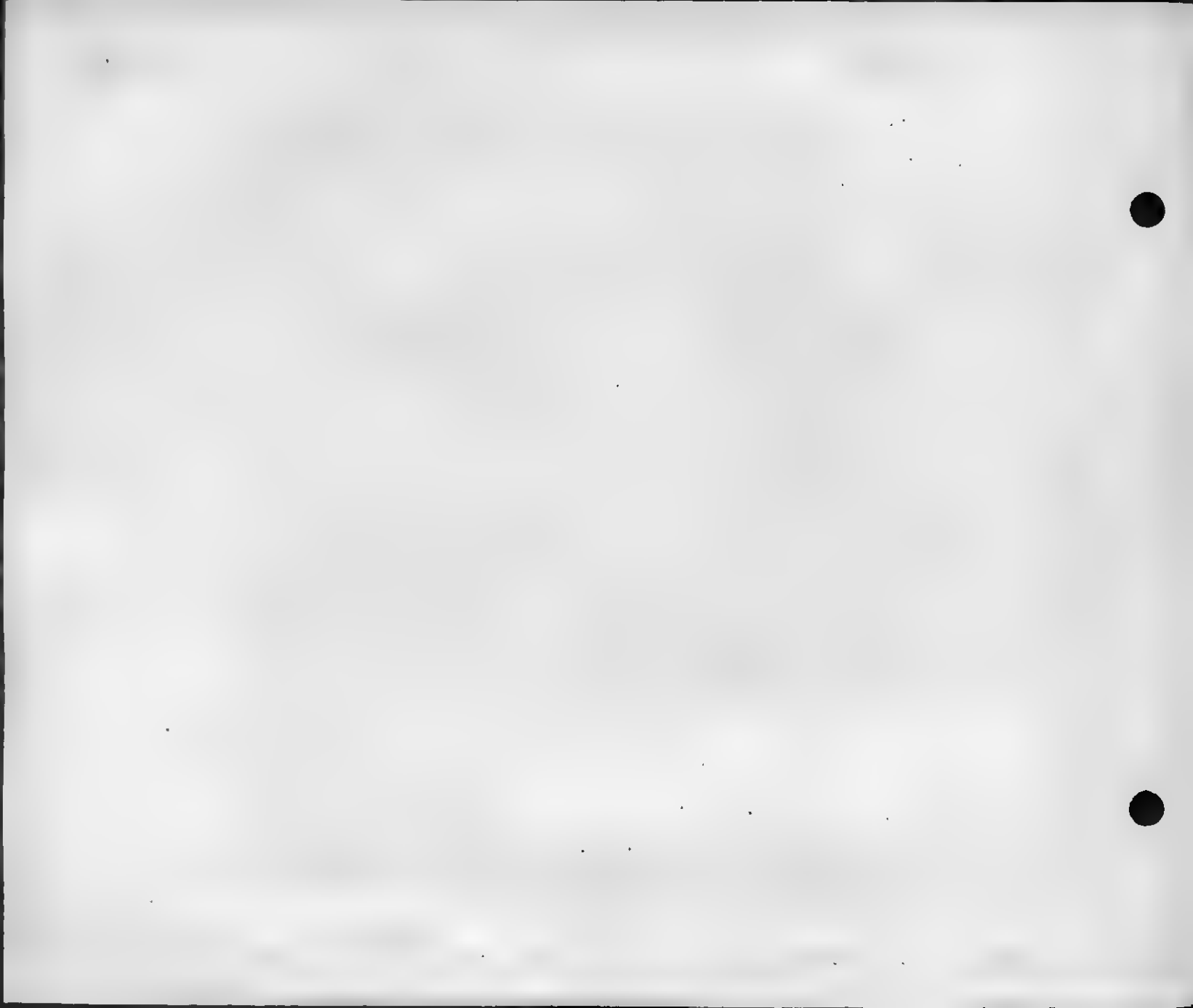
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02441		02398	
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>None</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>North Chevy Chase</u> d. STREET ADDRESS <u>8827 Kensington Pkwy</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>W</u> Last <u>Ballard</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>16</u> Year <u>1966</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>8/30/1882</u>
<b>9. AGE</b> (In years last birthday) <u>83</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>	
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Tennessee</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Richard M Ballard</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Sara Bradley</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service) <u>  </u>		<b>16. SOCIAL SECURITY NO.</b> <u>458-03-4675</u>	
<b>17. INFORMANT</b> <u>Rubie Baker</u> Address <u>8827 Kensington Pkwy North Chevy Chase, Md</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial failure</u> DUE TO (b) <u>Arteriosclerosis - cerebro-vascular renal disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>  </u>	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. INTERVAL BETWEEN ONSET AND DEATH</b> <u>1 1/2 hours</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a)</b> <u>Carcinoma of prostate. Prostatitis</u>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER.) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>None</u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>	<b>20f. (City or town) (County) (State)</b> <u>  </u>
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1956</u> <u>to</u> <u>present</u> , that (I) (we) last saw the deceased alive on <u>1/27/1966</u> , and that death occurred at <u>8 A</u> M, from the causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>John B. Umhan</u> M.D.		<b>22b. DATE SIGNED</b> <u>2/16/66</u>	
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOHN B. UMHAN</u>		<b>22d. ADDRESS</b> <u>8805 Conn. Ave. Ch. Ch. Md</u>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>2-18-1966</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Rockville Cemetery</u>	<b>23d. LOCATION</b> (City, town or county) (State) <u>Rockville Maryland</u>
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Cherry Chase Funeral Home</u> ADDRESS <u>3101 Wisc. Ave NW. Washington DC</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 21 1966</u>	<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



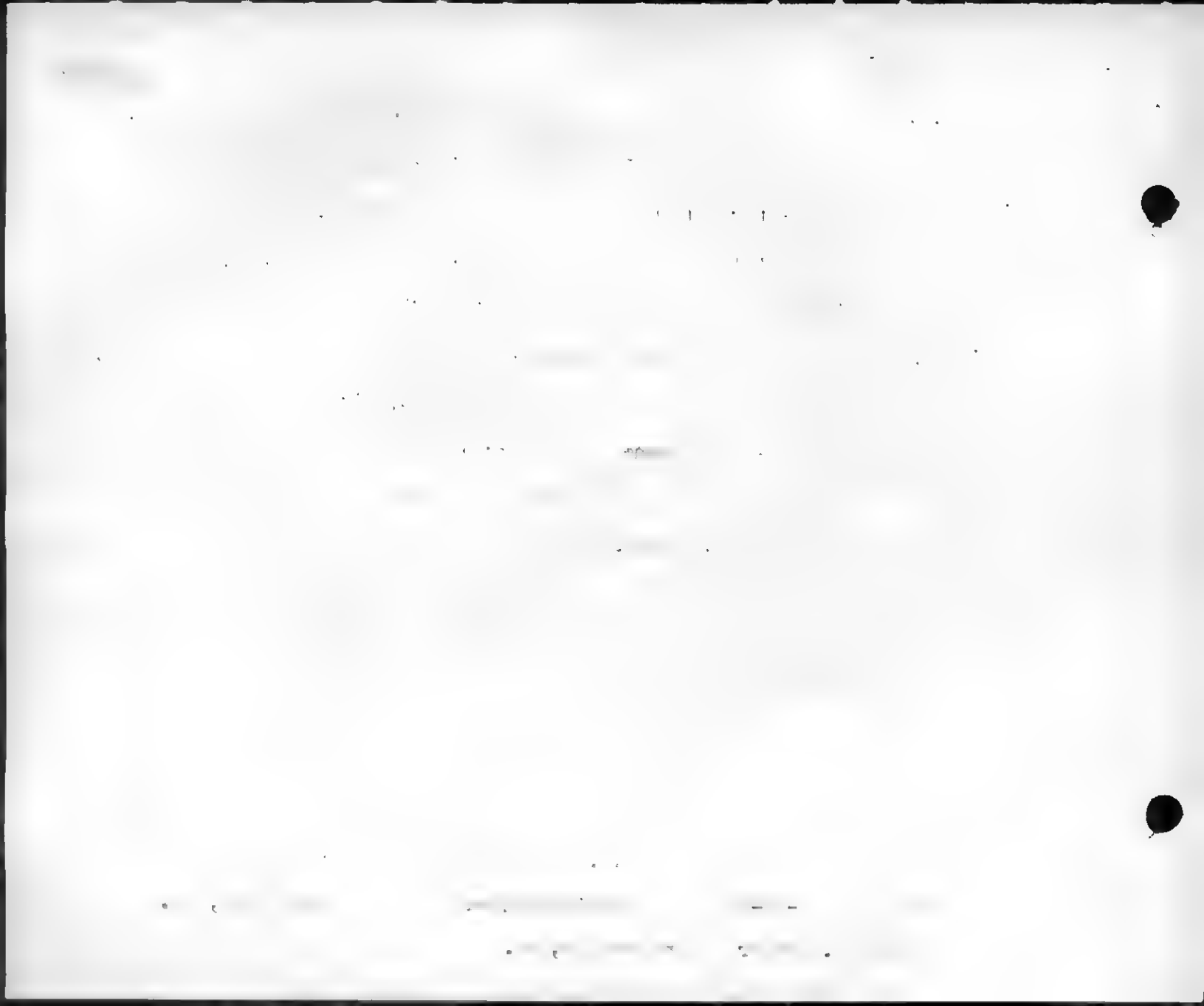


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b>				b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>				c. LENGTH OF STAY IN 1b <b>5 DAYS</b>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>								d. STREET ADDRESS <b>4112 GREAT OAK ROAD</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>VIRGINIA RIGGS BARTLETT</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>FEBRUARY 9 19 66</b>							
<b>5. SEX</b> <b>FEMALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDDED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>12-31-852</b>		<b>9. AGE (In years last birthday)</b> <b>81 yrs.</b>		<b>IF UNDER 1 YEAR</b> <input type="checkbox"/> <b>IF UNDER 24 HRS.</b> <input type="checkbox"/> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>GOVERNMENT WORKER</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>MARYLAND</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>			
<b>13. FATHER'S NAME</b> <b>HARRY RIGGS</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>LOUISA WOOD</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No --</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>HOSPITAL RECORDS</b>		Address			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)</b> <b>DISSECTING ANEURYSM - ABDOMINAL</b> <b>451X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>ATHEROSCLEROSIS</b> DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>7 DAYS</b> <b>YEARS</b>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from 2-2, 1966, to 2-9, 1966, that (I) (we) last saw the deceased alive on 2-8, 1966, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <i>Jack Schumacher</i>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <b>2-9-66</b>			
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>JACK SCHUMACHER, M.D.</b>						<b>22d. ADDRESS</b> <b>GAITHERSBURG, MARYLAND</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>2-11-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Rockville Union</b>		<b>23d. LOCATION (City, town or county)</b> (State) <b>Rockville, Md.</b>					
<b>24. FUNERAL DIRECTOR</b> <b>Francis H. Barber</b>						<b>ADDRESS</b> <b>Laytonsville, Md.</b>		<b>25a. REC'D BY REGISTRAR</b> <b>DATE FEB 11 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <i>Charles Judge</i>	

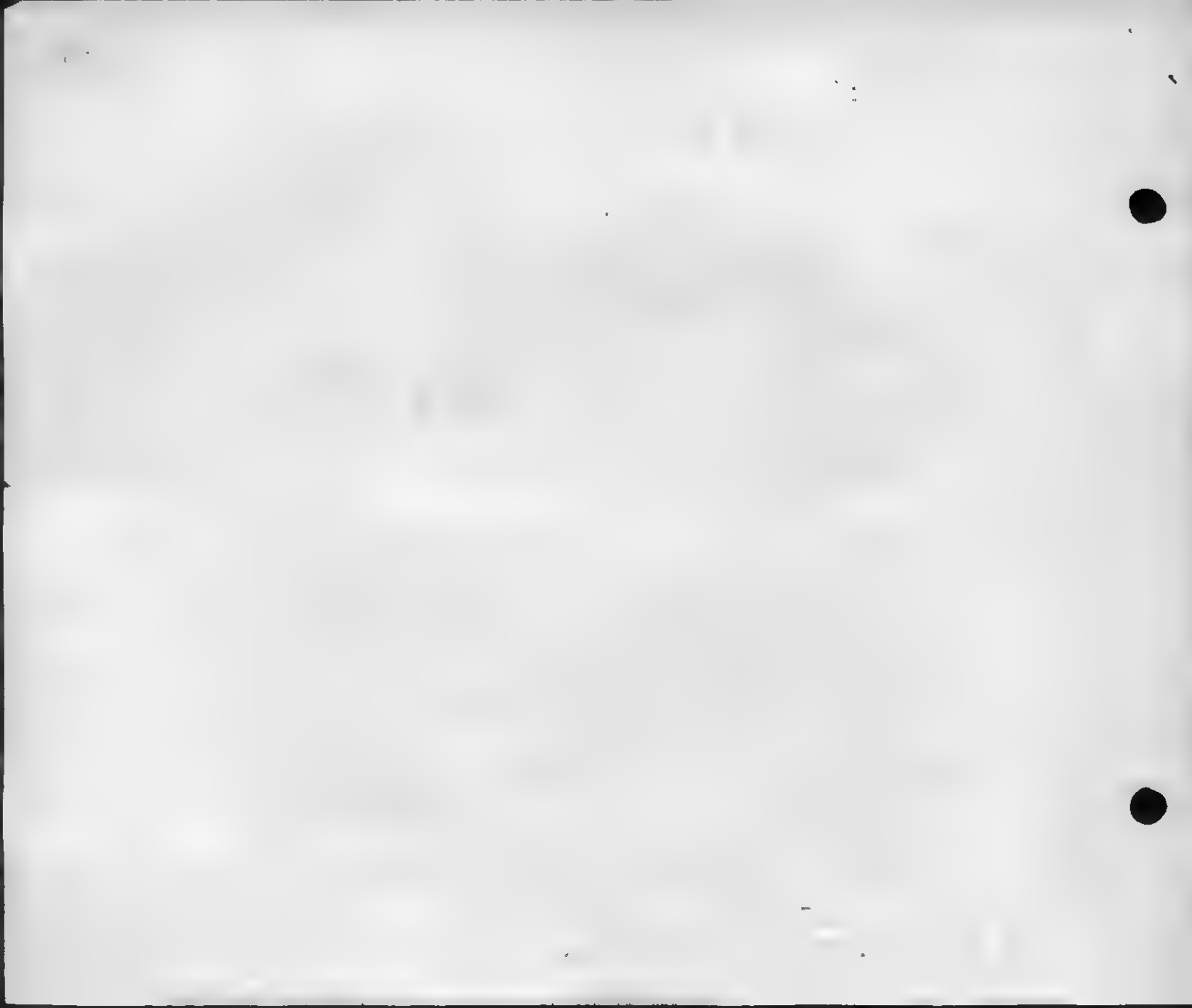


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
CERTIFICATE OF DEATH										
02443		02400								
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Olney</u> c. LENGTH OF STAY IN 1b <u>12 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Brook Grove Foundation (Sharon)</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mohican Hills</u> d. STREET ADDRESS <u>5445 Mohican Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Clyde</u> First <u>V</u> Middle <u>Beall</u> Last		4. DATE OF DEATH Month <u>2</u> Day <u>12</u> Year <u>1966</u>		5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Nashville Tenn.</u>		9. AGE (In years last birthday) <u>85</u> yrs. Months <u>7</u> Days <u>9</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>John Beall</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Passmore</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Daughter</u> Address <u>Mrs. E.C. Barrington</u> Same as Item 2.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>471X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (c), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Smoking, Admitted after release</u>										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>1 Dec 1953</u> to <u>1-26</u> 1966, that (I) (we) last saw the deceased alive on <u>2/10</u> 1966, and that death occurred at <u>15</u> P.M. from the causes and on the date stated above.										
22a. SIGNATURE <u>A.D. Bonifant</u> M.D.		22b. DATE SIGNED <u>2-12-66</u>		22c. PHYSICIAN'S NAME (Type) <u>A.D. BONIFANT</u>		22d. ADDRESS <u>52nd St. N.W.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-15-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>ROBERT A. PUMPHREY</u>		ADDRESS <u>Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>1-10-66</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>				

MEDICAL CERTIFICATION





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

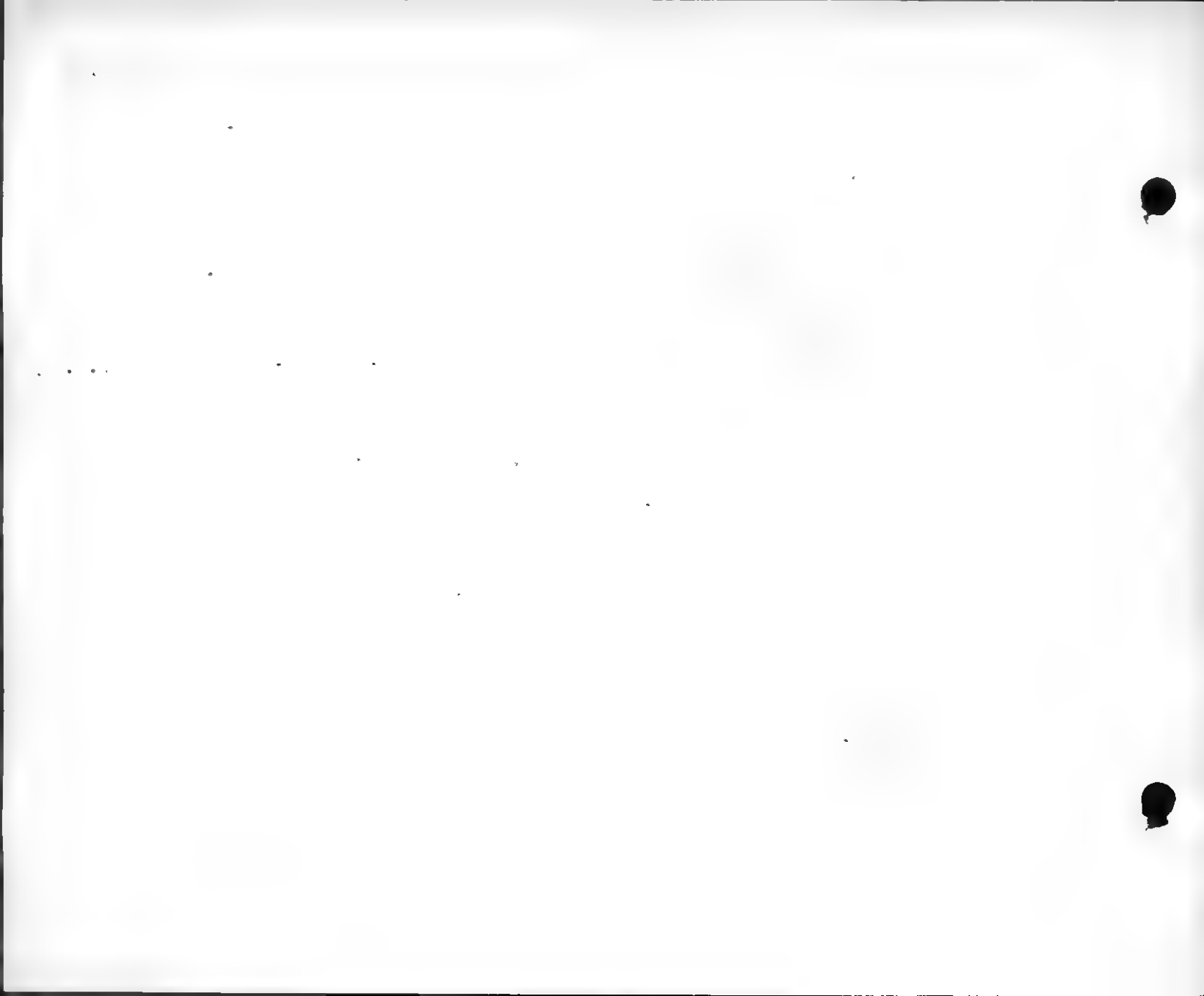
## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02444

02401

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <b>Maryland</b> b COUNTY <b>Montgomery</b>		
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c LENGTH OF STAY IN 1b <b>1 Hours</b>	c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>			d STREET ADDRESS <b>2711 Calgary Avenue</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>MEGHAN</b> Middle <b>THERESA</b> Last <b>BECKER</b>			4 DATE OF DEATH Month <b>Feb.</b> Day <b>3</b> Year <b>19 66</b>		
5 SEX <b>Female</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>12/2/65</b>	9 AGE (In years last birthday) yrs <b>2</b>	IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b KIND OF BUSINESS OR INDUSTRY <b>None</b>		11 BIRTHPLACE (State or foreign country) <b>Silver Spring, Md.</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13 FATHER'S NAME <b>G. Louis Becker</b>		
14 MOTHER'S MAIDEN NAME <b>Barbara L. Marino</b>			15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>No</b>		
16 SOCIAL SECURITY NO <b>None</b>			17 INFORMANT <b>G. Louis Becker</b>		
Address <b>2711 Calgary Ave Kensington, Md.</b>					
18 CAUSE OF DEATH (Enter on any one cause per se for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Cardiorespiratory Failure</b> DUE TO (b) <b>Secondary to asphyxiation in</b> DUE TO (c) <b>crib, accidental</b>					INTERVAL BETWEEN ONSET AND DEATH
PART 1 OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)					19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18) <b>Infant asphyxiated in crib.</b>			
20c TIME OF INJURY Month, Day, Year <b>2-3 1966</b>		20d INJURY OCCURRED While <input type="checkbox"/> at work or hot while <input checked="" type="checkbox"/> at work	20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Home</b>	20f (City or town) <b>Kensington</b>	(County) <b>Montgomery</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Belden R. Reap</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>Feb. 3, 1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b DATE THEREOF <b>2-5-66</b>	23c NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	23d LOCATION (City or Town) <b>Silver Spring, Md.</b>	(County) (State)
24 FUNERAL DIRECTOR <b>Harner E. Pumphrey, Inc.</b>		8434 ADDRESS <b>Silver Spring, Md.</b>		25a RECD BY REGISTRAR <b>FEB 9 1966</b>	25b REGISTRAR'S SIGNATURE <b>W. Judge</b>

5-169300

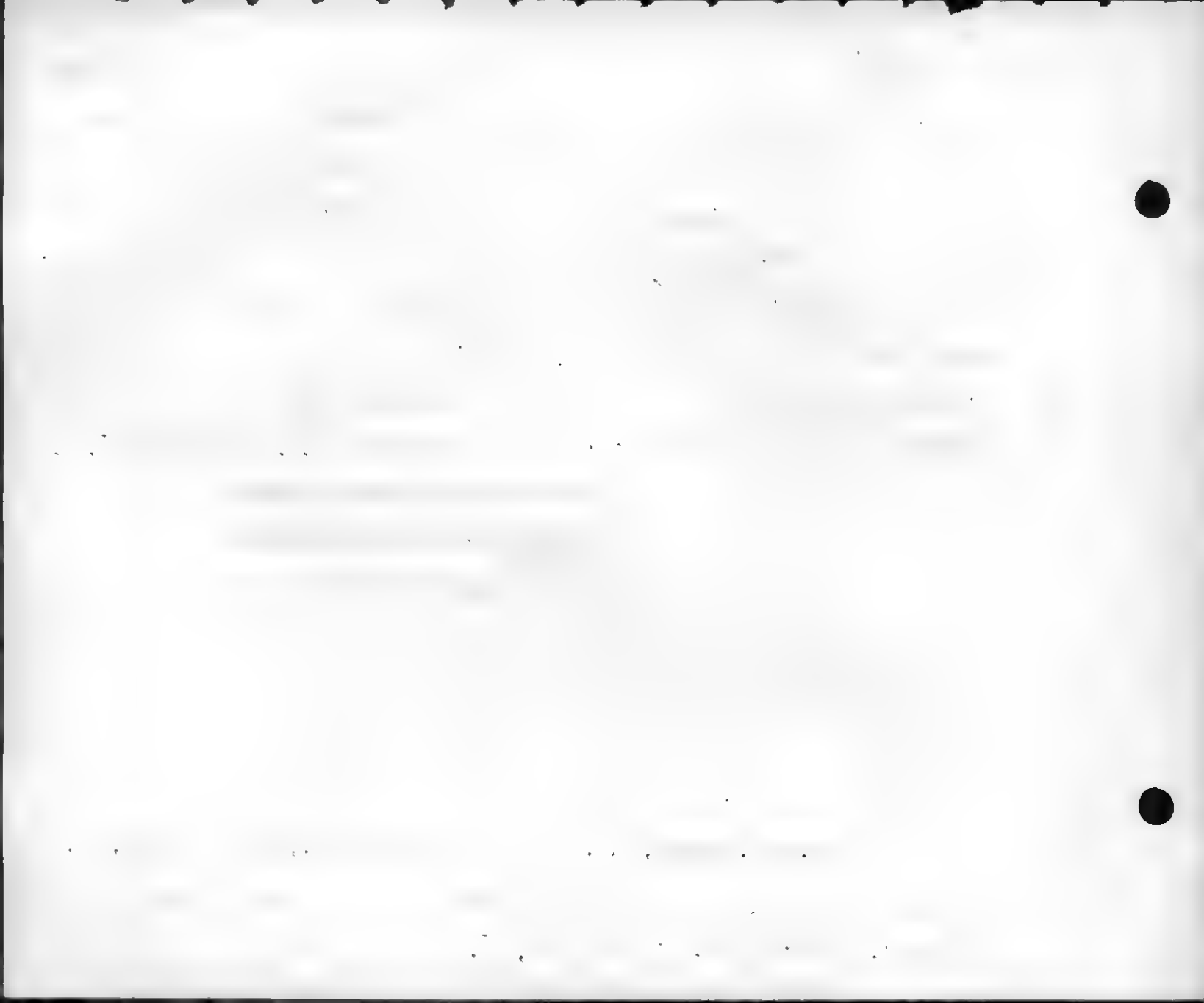


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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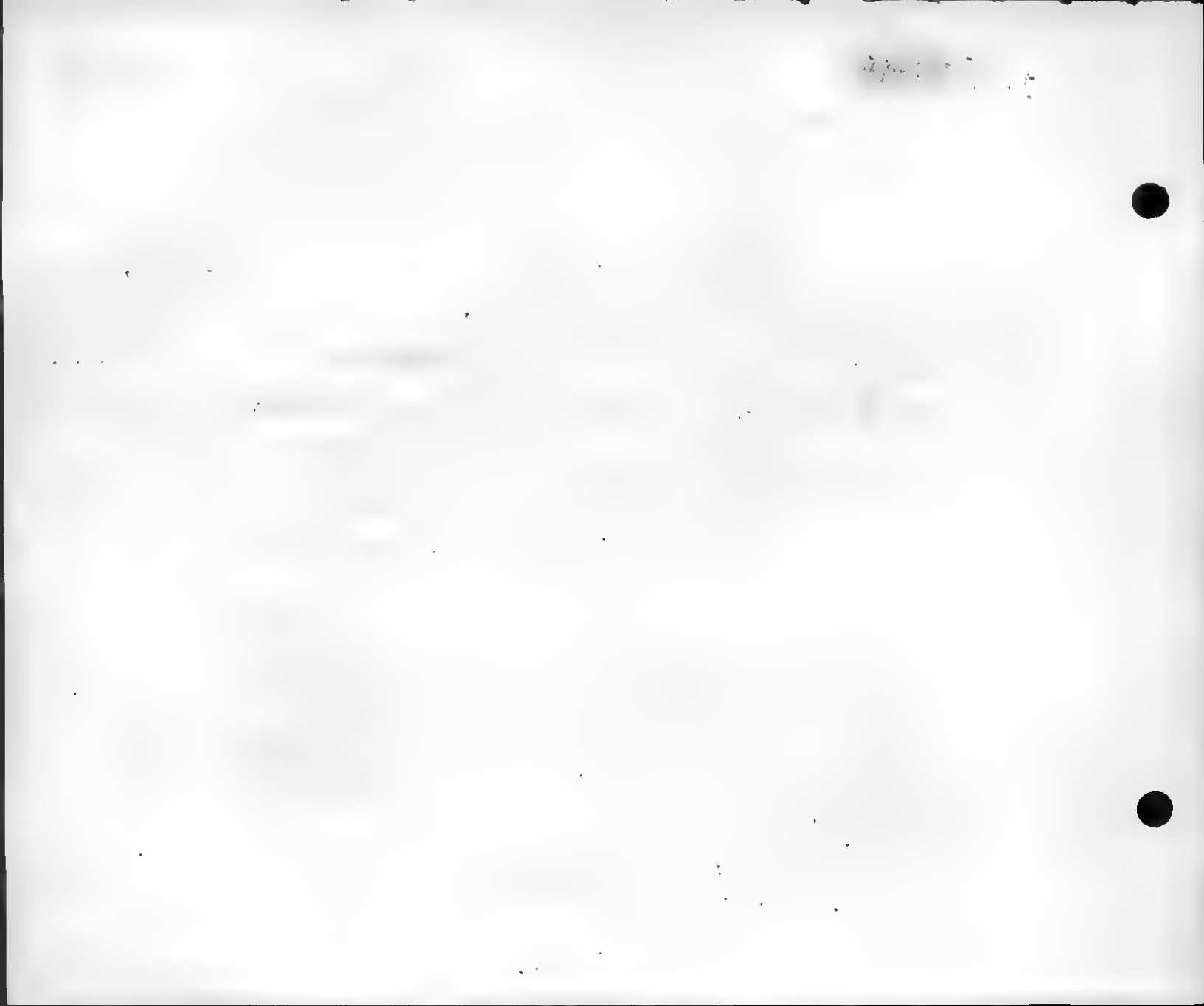
<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																	
<b>1. PLACE OF DEATH</b> a. COUNTY <b>MONTGOMERY</b> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b> c. LENGTH OF STAY IN 1b <b>1 week</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>					<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>800 Patton Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
<b>3. NAME OF DECEASED</b> (Type or print) First <b>SAMUEL</b> Middle <b>B</b> Last <b>BENNETT</b>			<b>4. DATE OF DEATH</b> Month <b>FEB.</b> Day <b>25</b> Year <b>1966</b>														
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>9/7/06</b>		<b>9. AGE</b> (In years last birthday) <b>59</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>AUDITOR</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>PUBLIC HOUSING ADM.</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>PA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>									
<b>13. FATHER'S NAME</b> <b>Richard Dana Bennett</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia Butterworth</b>													
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				<b>16. SOCIAL SECURITY NO.</b> <b>251-34-5025</b>		<b>17. INFORMANT</b> <b>Willis Bennett</b> Address <b>4410 Chesapeake St. N.W., Washington, D. C.</b>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <b>Acute peritonitis and pancreatitis</b> DUE TO (b) <b>Status following modified Whipples procedure</b> DUE TO (c) <b>Carcinoma head of pancreas</b>									<b>INTERVAL BETWEEN ONSET AND DEATH</b>								
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>																	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>									
<b>21. I certify that (I) (this hospital) attended the deceased from <u>2/21/1966</u>, to <u>2/25/1966</u> that (I) (we) last saw the deceased alive on <u>2/25/66</u> and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.</b>																	
<b>22a. SIGNATURE</b> <b>Thomas G. Edison M.D.</b>				<b>22b. DATE SIGNED</b> <b>Feb 25, 1966</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Thomas G. Edison, M.D.</b>											
<b>22d. ADDRESS</b> <b>1015 Spring St., Silver Spring, Md.</b>				<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>													
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>Feb 28, 1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>St. Mark's Cemetery</b>		<b>23d. LOCATION</b> (City, town or county) (State) <b>Fairland Maryland</b>											
<b>24. FUNERAL DIRECTOR</b> <b>Warner E. Pumphrey, Inc. Silver Spring, Md.</b>				<b>25a. REC'D BY REGISTRAR</b> <b>FEB 28 1966</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>1</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1015 DeBeck Drive</u>								d. STREET ADDRESS <u>1015 DeBeck Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>PAULINE</u> Middle <u>P.</u> Last <u>BESSER</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>9</u> Year <u>19 66</u>							
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Oct. 1894</u>		<b>9. AGE</b> (In years last birthday) <u>71</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>  </u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unknown Peace</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Laura <del>Peace</del> Unknown</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>  </u> (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>  </u>		<b>17. INFORMANT</b> <u>Georgia Ray--Cousin--Address above item #2</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) <u>Cerebral Encephalomalacia</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>4 Days</u> <u>2 years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not White at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, off. bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>December 1965</u> <b>to</b> <u>Feb. 9, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 9, 1966</u> , <b>and that death occurred at</b> <u>11:30 AM</u> , <b>from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>William Frank</u>						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>M.D.</b>		<b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>Feb. 9, 1966</u>	
<b>22c. PHYSICIAN'S NAME (Type)</b> <u>WILLIAM FRANK, M.D.</u>						<b>22d. ADDRESS</b> <u>1125 ROCKVILLE PIKE, ROCKVILLE</u>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2/12/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Mount Rose Cemetery</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>York, Pennsylvania</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Tyson Wheeler</u>				<b>ADDRESS</b> <u>1331 Rockville Pike, Rockville Maryland</u>				<b>25a. REC'D BY REGISTRAR</b> <u>FEB 14 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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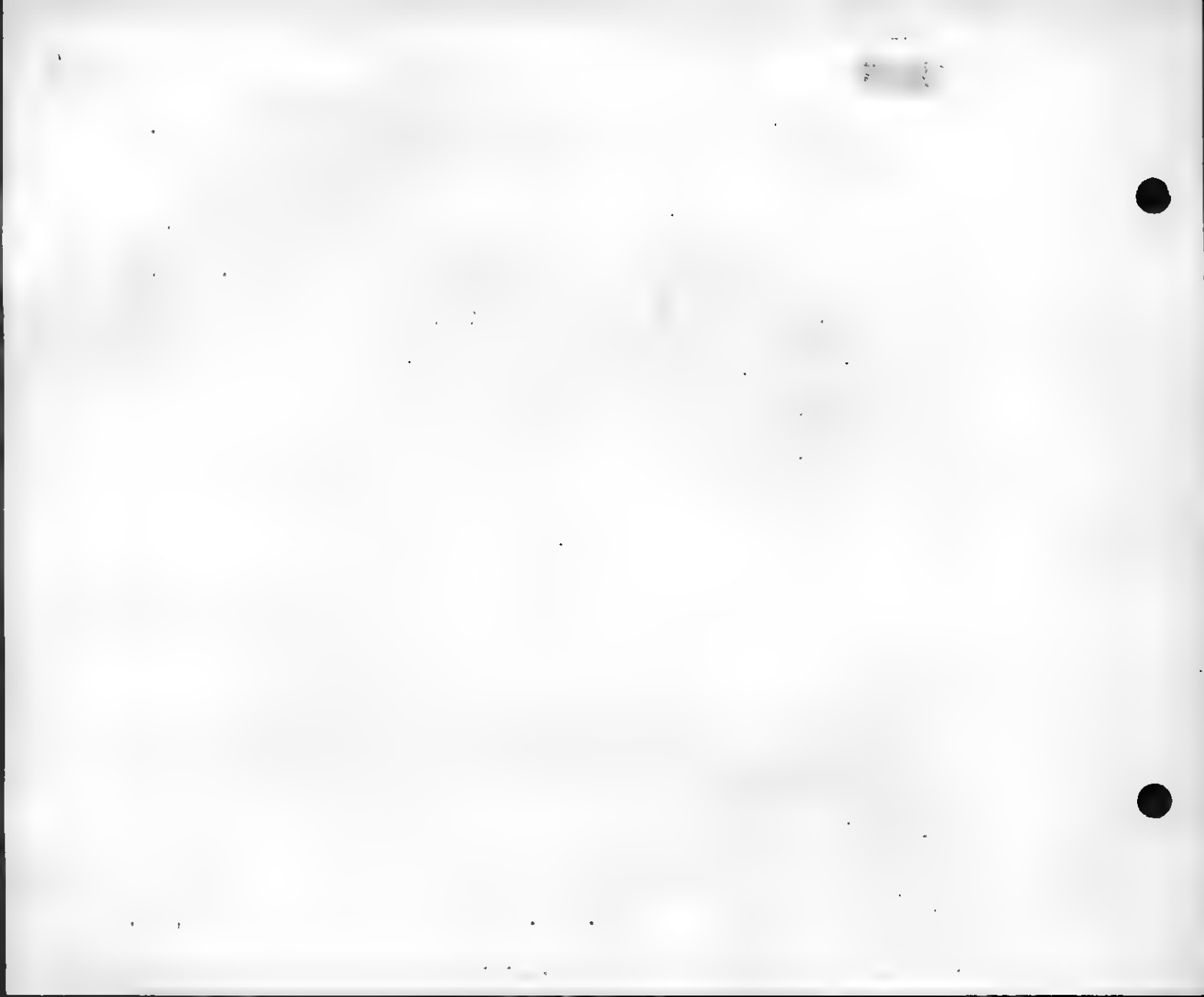
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02447

CERTIFICATE OF DEATH

02404

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. Geo.</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Hyattsville</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanatorium</b>		d. STREET ADDRESS <b>2027 Rittenhouse Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JACOB</b> Middle <b>BLAFKIN</b> Last <b>BLAFKIN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/15/1888</b>
9. AGE (In years last birthday) <b>77</b> yrs		10. IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>	11. IF UNDER 24 HRS Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min <b>77</b>
10a. US. AL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Store Owner (Ret)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Samuel Blafkin</b>		14. MOTHER'S MAIDEN NAME <b>Mollie</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>Bess Blafkin</b>		Address <b>same as 2 above</b>	
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cerebro-Vascular accident</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Art. Hypertensive Hpt. Dis.</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs.</b> <b>years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. <b>19</b> Month, Day, Year p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 1960, to <b>Feb 25</b> , 1966, that (I) <b>(was)</b> last saw the deceased alive on <b>Feb 25</b> , 1966, and that death occurred at <b>10:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Isidore Shulman</b>		22b. DATE SIGNED <b>2-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>ISIDORE SHULMAN</b>		22d. ADDRESS <b>9-15-19th St. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Natl. Mem. Park</b>	23d. LOCATION (City or Town) (County) (State) <b>Falls Church, Va.</b>
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home 4217 9th Street N.W.</b>		25a. REC'D BY REGISTRAR <b>11-1-1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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VS A15 (4)  
15M 9/58

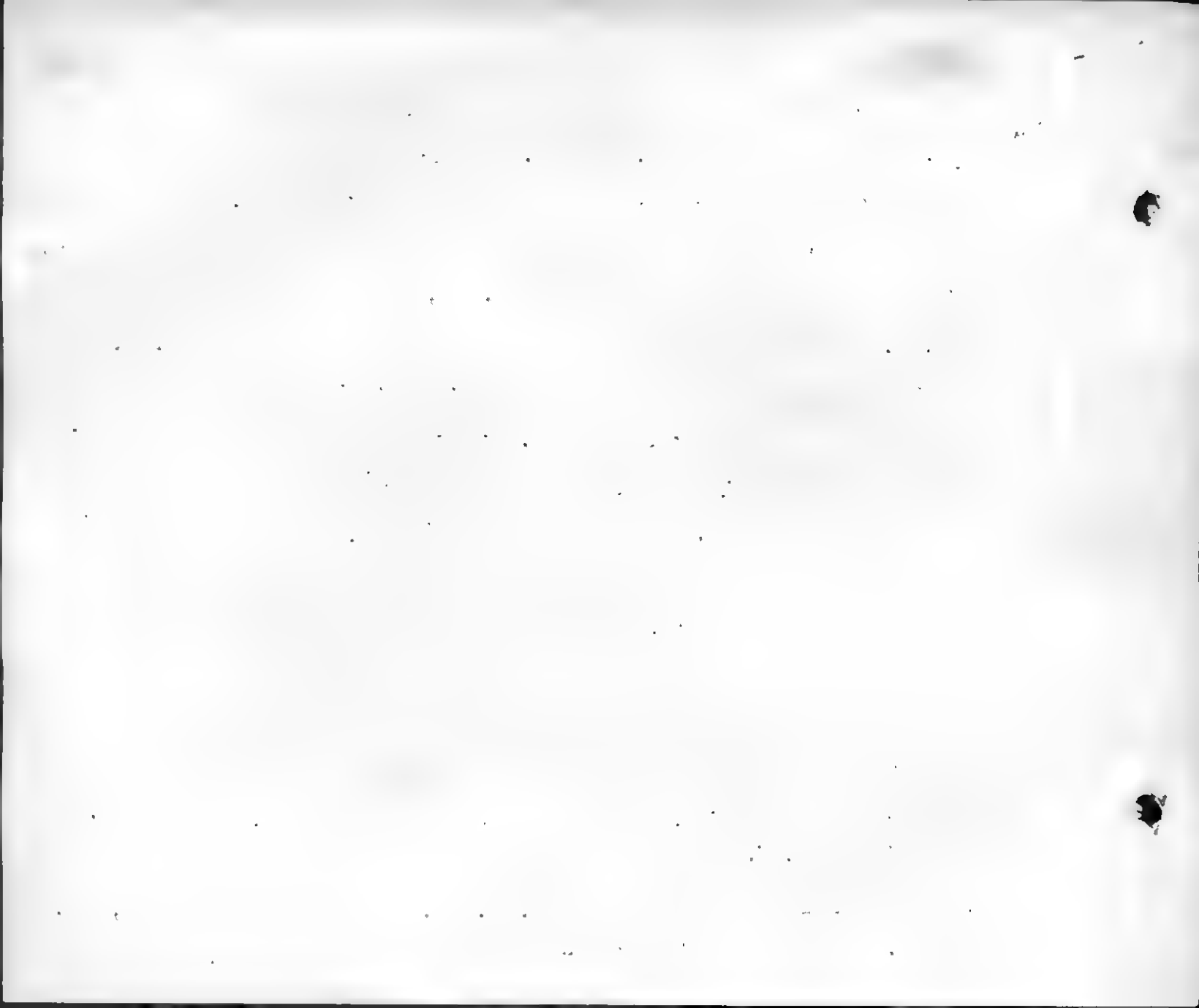
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 02405

02448

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		c. LENGTH OF STAY IN 1b <b>1 yr. 4½ Mos.</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION <b>Potomac Valley Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Florence</b> First <b>Bonifant</b> Middle Last		4. DATE OF DEATH <b>Feb</b> Month <b>5</b> Day <b>1966</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 21, 1874</b>
9. AGE (In years last birthday) <b>91</b> yrs.		IF UNDER 1 YEAR <b>2</b> Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XXXXX Editor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>James Bonifant</b>		14. MOTHER'S MAIDEN NAME <b>Laura Craigen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Unknown</b>	
INFORMANT <b>Neice</b>		Address <b>Same as Item 2.</b>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the under-lying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>years</b>	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
19a. TIME OF INJURY Month Day, Year Hour a. m. p. m. <b>19</b>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20b. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 1</b> , 19 <b>66</b> , to <b>Feb</b> , 19 <b>66</b> that I last saw the deceased alive on <b>Feb 1</b> , 19 <b>66</b> , and that death occurred at <b>2:40 AM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>James W. Egan</b>		ADDRESS (Street, city or town, state) <b>5413 Cedar Lane Bethesda Maryland</b>	
PHYSICIAN'S NAME (Type) <b>JAMES W. EGAN</b>		DATE SIGNED <b>2/5/66</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-7-66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Potomac Meth. Ch. Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Montgomery County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b>		ADDRESS <b>Bethesda, Maryland</b>	
24a. REC'D BY REGISTRAR <b>553</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
DATE <b>14 1966</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02449

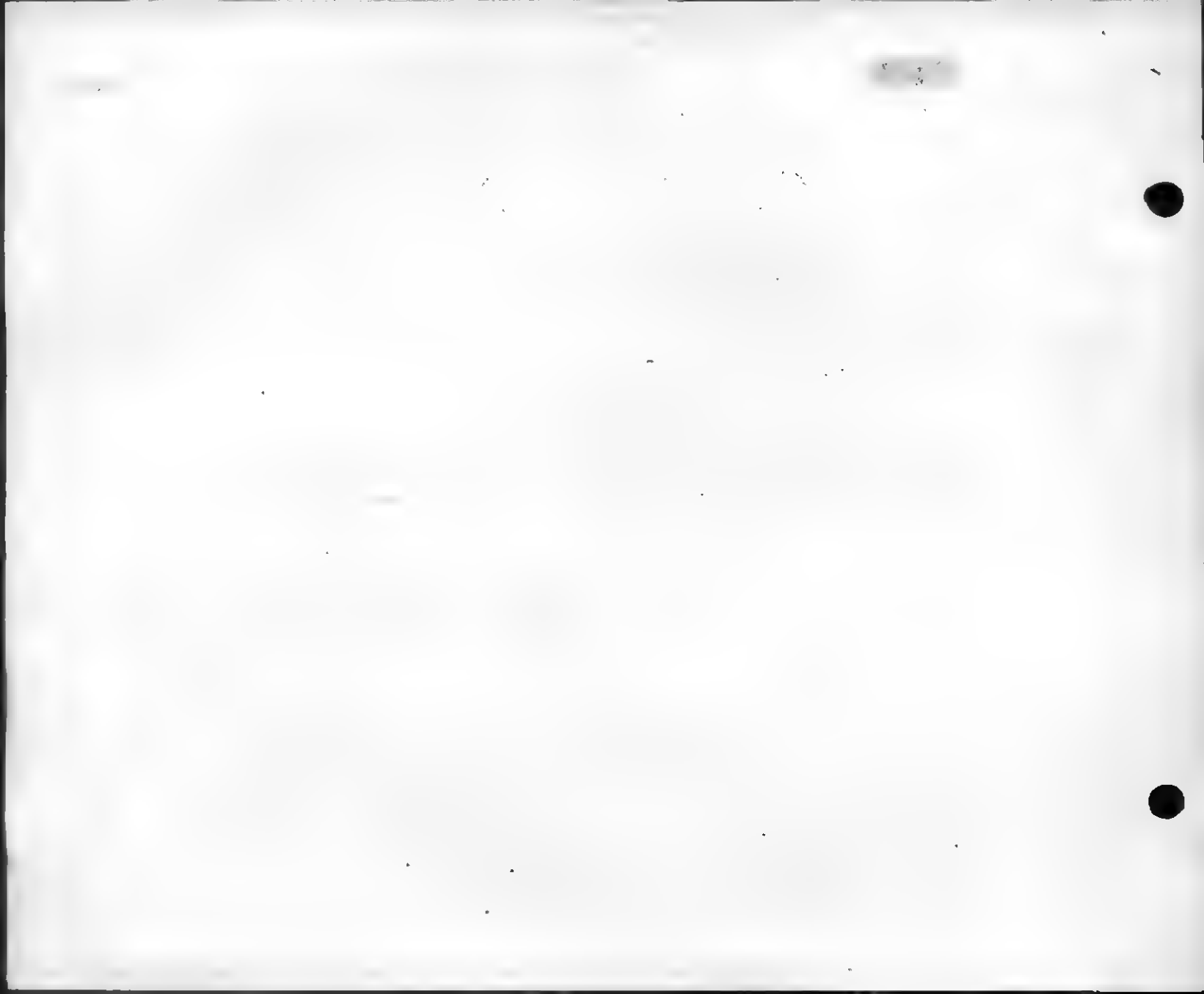
## CERTIFICATE OF DEATH

02406

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>St. BURBANK</u>		d. STREET ADDRESS <u>4421 Fickett Street</u>	
3 NAME OF DECEASED (Type or print) <u>James Boone</u>		4. DATE OF DEATH Month <u>2</u> Day <u>4</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-31-13-52</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	9 AGE (in years last birthday) yrs <u>6</u> IF UNDER 1 YEAR Months <u>3</u> IF UNDER 24 HRS Hours <u>19</u> Min. <u>66</u>
11. BIRTHPLACE (County & State, or foreign country) <u>Durham, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Ruth YACKET</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>Unknown</u>	
17. INFORMANT <u>Lloyd T. Boone Husband</u>		Address <u>Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Abdominal Carcinomatosis</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of rectum</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-21</u> , 19 <u>66</u> , to <u>2-4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-3</u> , 19 <u>66</u> , and that death occurred at <u>8 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Fredrick B. Hartsock</u> M.D.		22b. DATE SIGNED <u>2-4-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Fredrick B. Hartsock</u>		22d. ADDRESS <u>2218 W. Main Ave. Beth Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial-transit 2/4/66</u>	23b. DATE THEREOF <u>2/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Mem. Park</u>	23d. LOCATION (City or Town) (County) (State) <u>Durham, North Carolina</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a. REC'D BY REGISTRAR <u>Bethesda, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>FEB 14 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.



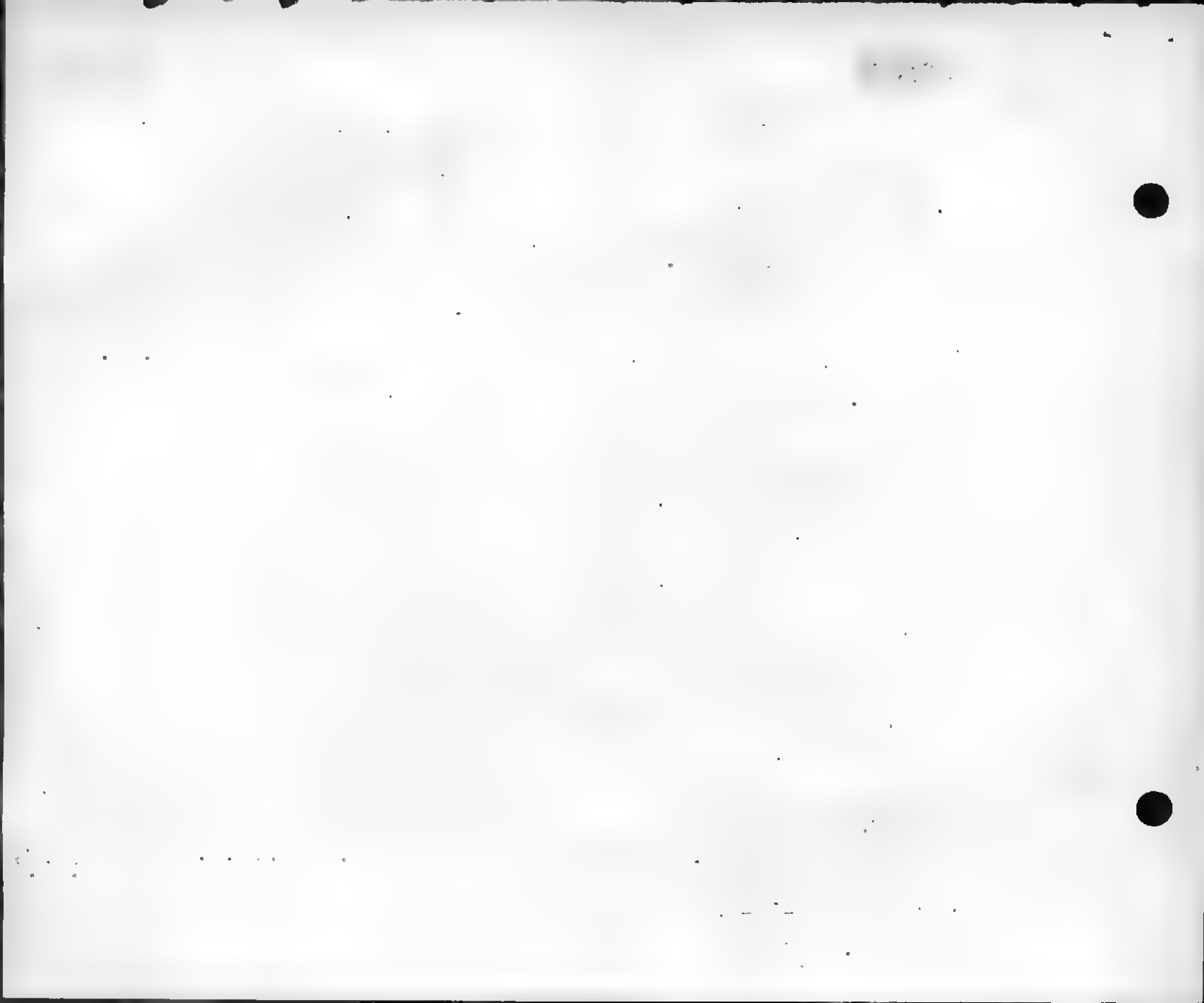
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN MD <b>1-MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4906 River Road</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4906 River Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>George A. Borresen</b>		4. DATE OF DEATH <b>February 22 1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 22, 1884</b>
9. AGE (In years last birthday) <b>81</b> yrs.		10. IF UNDER 1 YEAR <b>11</b> Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Denmark</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Peter N. Borresen</b>		14. MOTHER'S MAIDEN NAME <b>Mary Paulsen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT <b>Brother</b>		Address <b>Harry Borreson</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arterio Sclerosis</b> (c) <b>Obesity</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Atheromata Aorta Carcinoma Prostate</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2 April, 1965</b> to <b>22 Feb., 1966</b> , that (I) (we) last saw the deceased alive on <b>1 January 1966</b> , and that death occurred at <b>5 P.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Wm H. Beard</b>		22b. DATE SIGNED <b>23 Feb. 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>WILLIAM H. BEARD</b>		22d. ADDRESS <b>2814 Conn. Ave., N.W., Washington, D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-28-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>		25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>MAR 3 1966</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

# MARYLAND STATE DEPARTMENT OF HEALTH

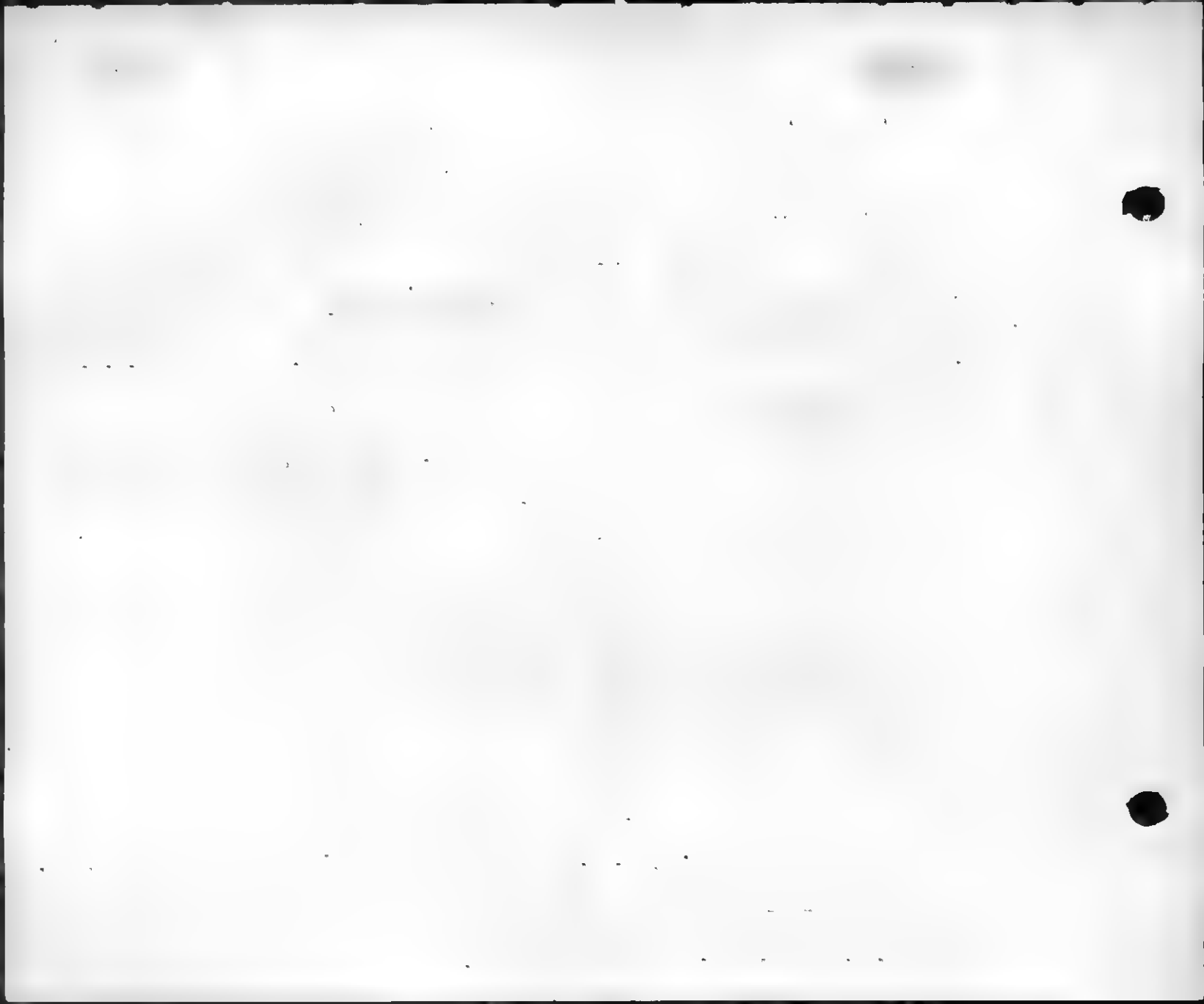
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02451

02408

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN 1b <i>4 years</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>8329 Grubb Road</i>				d. STREET ADDRESS <i>8329 Grubb Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>GOLDIE</i> Middle <i>B.</i> Last <i>BOYER</i>				4. DATE OF DEATH Month <i>February</i> Day <i>23</i> Year <i>1966</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 1, 1891</i>	9. AGE (In years last birthday) <i>74 yrs.</i>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own home</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Kansas City, Mo.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Harland Kitterman</i>				14. MOTHER'S MAIDEN NAME <i>Pet Sills</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Charles N. Boyer</i>		Address <i>8329 Grubb Road, Silver Spring, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4201</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus</i>							INTERVAL BETWEEN ONSET AND DEATH <i>Weeks</i> <i>Yes</i>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Sept.</i> 19 <i>61</i> to <i>Jan. 23</i> , 1966, that (I) <del>we</del> last saw the deceased alive on <i>Jan 16</i> , 1966, and that death occurred at <i>10:30</i> PM, from the causes and on the date stated above.							
22a. SIGNATURE <i>Gene U. Cohen</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Jan 26, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Gene U. Cohen, M.D.</i>				22d. ADDRESS <i>1106 Spring Street, Silver Spring, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>2-28-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Silver Spring, Maryland</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



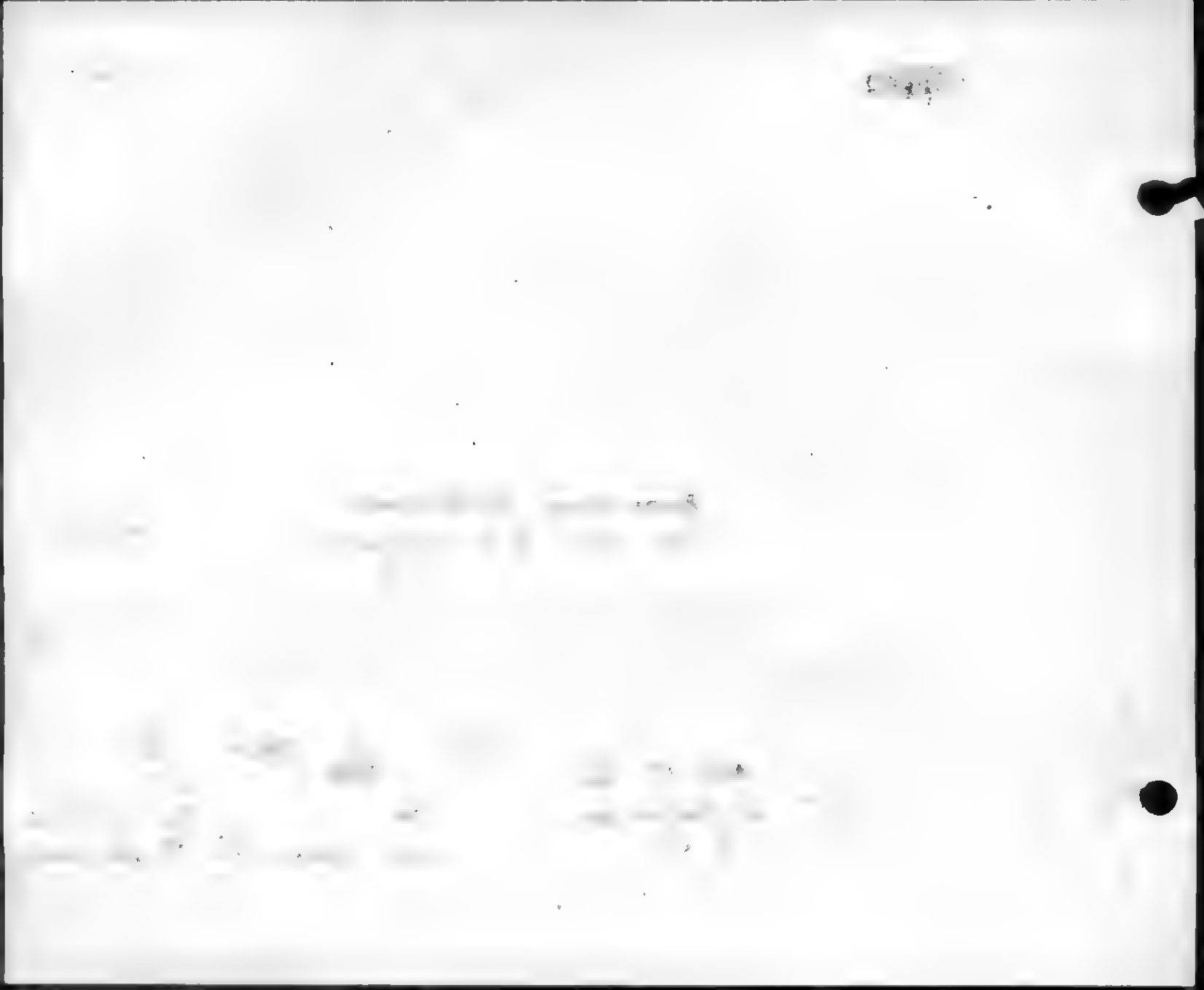


02409

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <u>MARYLAND</u> c. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. LENGTH OF STAY IN 1b <u>7 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>2817 PARKER CT</u>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E</u> Last <u>BOYER</u>		4 DATE OF DEATH Month <u>FEB</u> Day <u>18</u> Year <u>1966</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>1912</u> <u>3-22-11</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction Foreman</u>		10b. KIND OF BUSINESS OR INDUSTRY	9 AGE (in years last birthday) <u>54.3</u>
11 BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
3 FATHER'S NAME <u>William Boyer</u>		14. MOTHER'S M.A.DEN NAME <u>MYRTLE BROWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>U.S. Army</u>		16 SOCIAL SECURITY NO <u>413-09-4509</u>	
17 INFORMANT <u>Wife - Margaret Etc.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: <u>1621</u> IMMEDIATE CAUSE (a) <u>Bronchial Obstruction</u> DUE TO (b) <u>McC. Ca. bronchogenic</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 week</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>Hour</u> <u>a.m.</u> <u>19</u> <u>p.m.</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>65</u> , to <u>Feb</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Feb 17</u> , 19 <u>66</u> , and that death occurred at <u>3:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>V.C. DeFurnum</u> M.D.		22b. DATE SIGNED <u>Feb 18, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>1150 Connecticut Ave Wash D.C.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>21 FEB 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL</u>	23d. LOCATION (City or Town) (County) (State) <u>ARLINGTON VA.</u>
24. FUNERAL DIRECTOR <u>Quigley Funeral Home Inc. 7400 Georgia Ave. N.W. DC 20012</u>	25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02410

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Emory Grove</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sandy Spring</u>	
c. LENGTH OF STAY IN 1d <u>4 days</u>		d. STREET ADDRESS <u>?</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RFD. Gaithersburg</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Howard</u> Middle <u>Sylvester</u> Last <u>Braxton</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1966</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/25/1939</u>
9. AGE (in years last birthday) <u>26</u> yrs		10. IF UNDER 1 YEAR Months <u>26</u> Days <u>26</u> Hours <u>26</u> Min <u>26</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Braxton</u>		14. MOTHER'S MAIDEN NAME <u>Ethel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute Hemorrhagic Pancreatitis</u> 3240 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Acute and Chronic Alcoholism</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		22. DATE SIGNED <u>2/1/66</u>	
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2/4/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Emory Grove Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Emory Grove Md.</u>
24. FUNERAL DIRECTOR <u>John T. ...</u>		25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

105

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

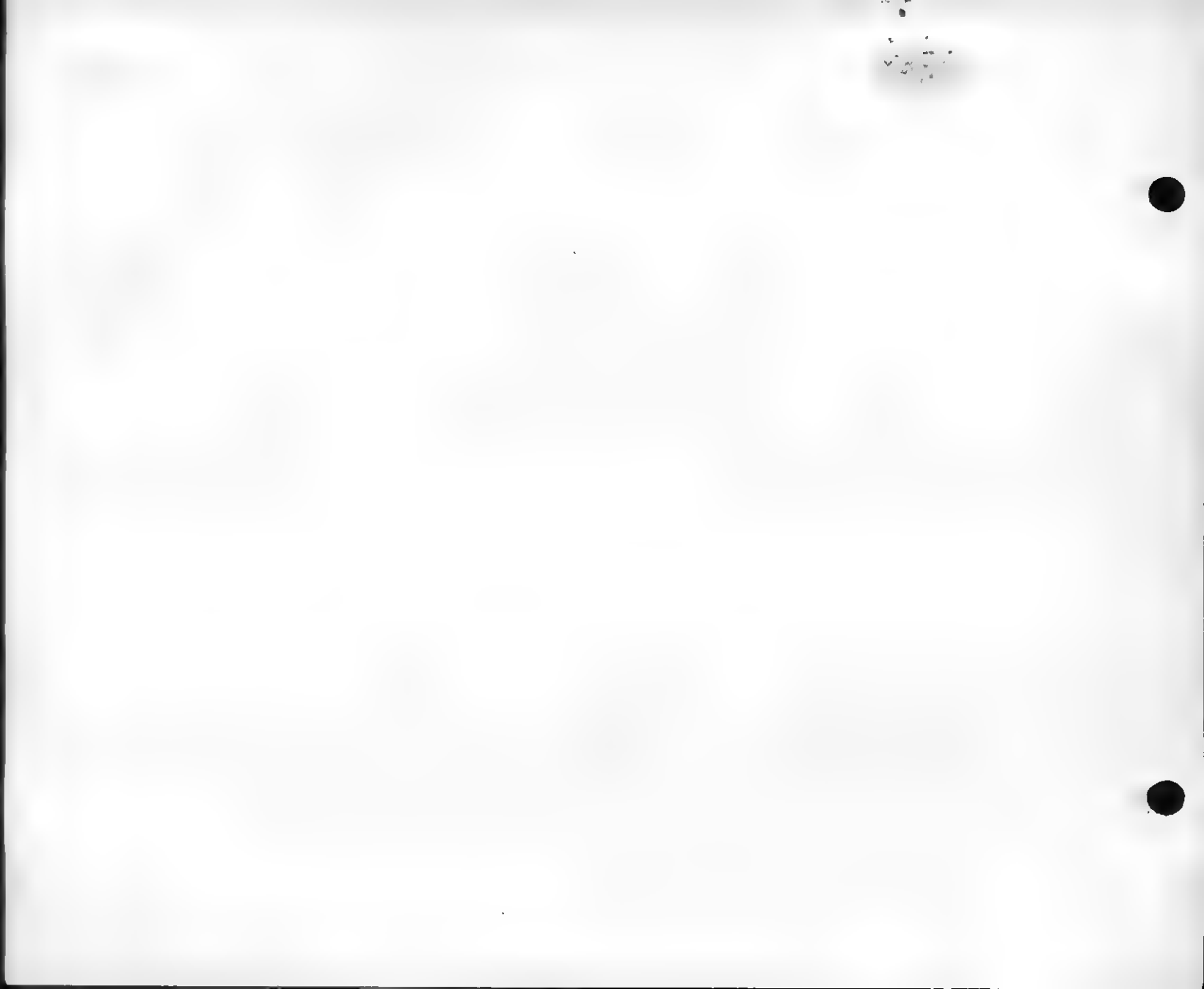
02454

02411

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6215 Goldsboro Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Brady Boy "A" Briscoe</u>		4. DATE OF DEATH <u>2 - 18</u> 19 <u>66</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-66</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State or foreign country) <u>Mont. Co. Md.</u>
13. FATHER'S NAME <u>Anthony Wellesley Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Zahava Goldfoot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT <u>Father</u> Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity</u> 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Anna L. H. [illegible] M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>2/23/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Suburban Hospital</u>	23d. LOCATION (City or town) (County) (State) <u>Bethesda - Montgomery - Md.</u>
24. FUNERAL DIRECTOR <u>Mrs. Amelia C. Carter</u> ADDRESS <u>Administrators</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>FEB 28 1966</u>	25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02155

## CERTIFICATE OF DEATH

02412

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6215 Galesburg Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Betty Boy "B" Briscoe</u>		4. DATE OF DEATH Month <u>2</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-18-66</u>
9. AGE (in years last birthday) <u>15</u>		10. F UNDER 1 YEAR Months Days Hours Min IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Mont. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Anthony Wellesley Briscoe</u>		14. MOTHER'S MAIDEN NAME <u>Zahava Gold Foot</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Father</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>immaturity</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.			
22a. SIGNATURE <u>Clara M. Van Rooy</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)	
24. FUNERAL DIRECTOR <u>Mrs. Amelia C. Carter</u>		25a. REC'D BY REGISTRAR DATE <u>FEB 28 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7-11-12



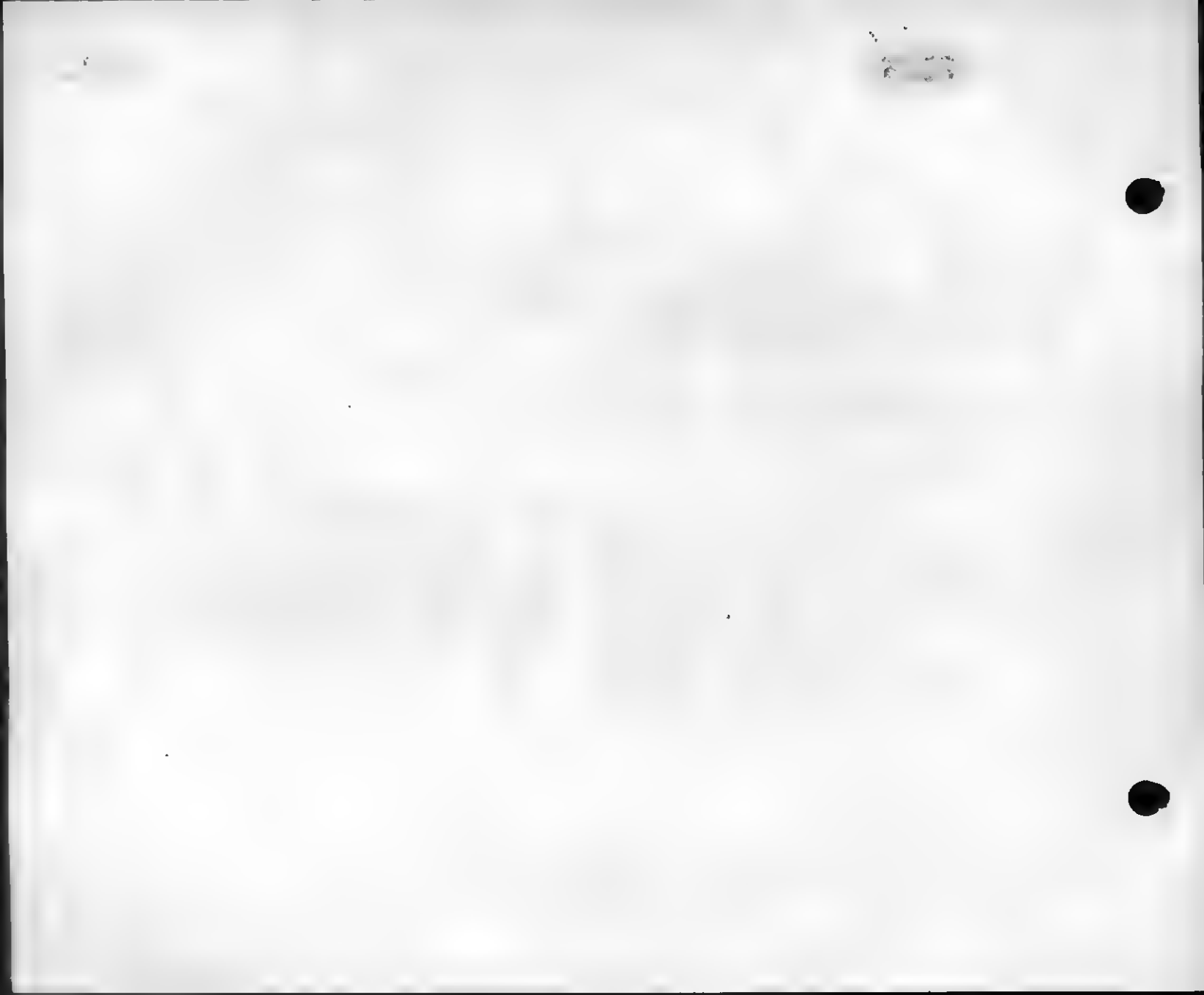


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02456  
CERTIFICATE OF DEATH  
02413

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN 1b <u>1 MONTH</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL HALL NURSING HOME</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>ARLINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS <u>1212 S. OAK CREST RD</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE</u> <u>BROOKS</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY</u> <u>3</u> <u>1966</u>	
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR. 24 1890</u>
9. AGE (In years last birthday) <u>75</u> yrs. FINDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RET.-SCHOOL TEACHER</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>FREDERICK STRUMBERGER</u>	
14. MOTHER'S MAIDEN NAME <u>EVA MYERS</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. <u>231-62-7868</u>		17. INFORMANT Address <u>ETHEL B. YOUNG SISTER-IN-LAW 5012-45th ST. N.W., D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (b) <u>ESSENTIAL HYPERTENSION</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CEREBRAL HEMORRHAGE</u> INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 14, 1965</u> to <u>FEB 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB 3, 1966</u> , and that death occurred at <u>HOME</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>FEB 3, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d. ADDRESS <u>5206 N. ... CHERRY CHASE, W.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-7-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SUITLAND MD.</u>	
24. FUNERAL DIRECTOR <u>Jos. Hawkes Sons Inc. Wash. D.C.</u>		25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02457						02414					
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>3-DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9809 Cantol View Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>Brown</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>1966</u>			5. SEX <u>male</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Feb. 8, 1876</u>			9. AGE (In years last birthday) <u>89</u> yrs.			IF UNDER 1 YEAR Months <u>89</u> Days <u>1</u> Hours <u>19</u> Min. <u>66</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired interior decorator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Decorating</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Forest Glen, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Edward Brown</u>				14. MOTHER'S MAIDEN NAME <u>Cissel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>YES</u>				17. INFORMANT <u>Alger Y. Barbee</u> Address <u>9809 Capitol View Avenue Silver Spring, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Generalized Cerebral Occlusion</u> DUE TO (c) <u>1042</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1956</u> to <u>Feb 1, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1, 1966</u> , and that death occurred at <u>7:42 M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>W. B. Wardrop</u>				22b. DATE SIGNED <u>2/2/66</u>				22c. PHYSICIAN'S NAME (Type) <u>W. B. Wardrop</u>			
22d. ADDRESS <u>800 Pershing Drive, Silver Spring, Md.</u>				23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>							
23b. DATE THEREOF <u>2-4-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Rockville, Maryland</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1994

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

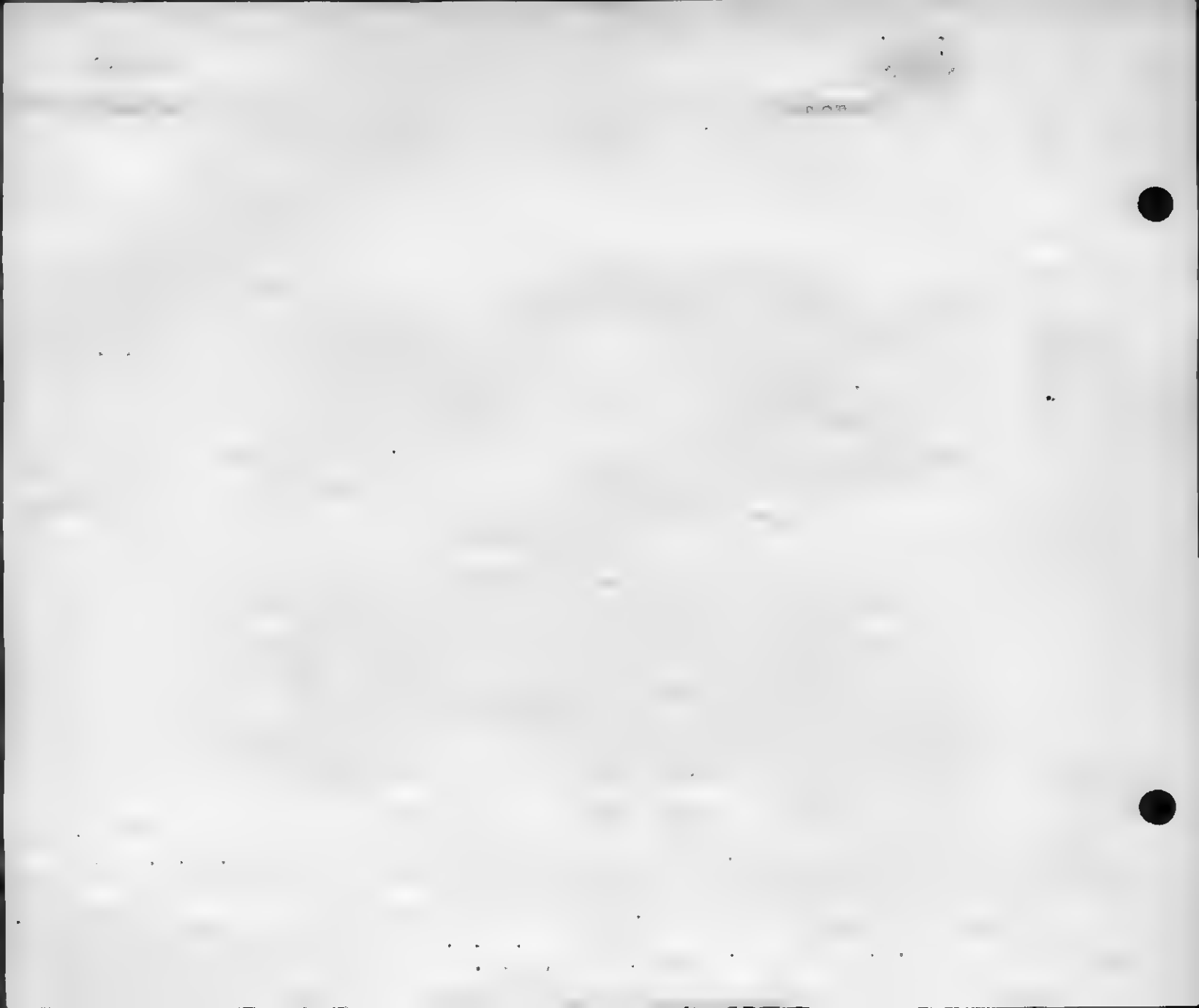
## CERTIFICATE OF DEATH

02458

02415

1. PLACE OF DEATH e. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution. Reside a before admission) e. STATE <b>Maryland</b>		b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hillandale</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Hillandale</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1766 Overlook Drive</b>		d. STREET ADDRESS <b>1766 Overlook Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Luella</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>February</b> Day <b>14</b> Year <b>1966</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/7/71</b>	9. AGE (In years last birthday) <b>95</b> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>	
13. FATHER'S NAME <b>Limon D. Sabin</b>		14. MOTHER'S MAIDEN NAME <b>Susan Dexter</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Luella V. Miles same as #2</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ruptured abdominal aorta</b> <b>451X</b> DUE TO <b>Aneurysm</b> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO <b>Arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>?</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1953 to 14 Feb 1966</b> that (I) <b>(was)</b> last saw the deceased alive on <b>12 Feb 1966</b> , and that death occurred at <b>4:10 PM</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>William D. Aud</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>2/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>William D. Aud</b>		22d. ADDRESS <b>9006 Colesville Rd. S.S. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>cremation</b>		23b. DATE THEREOF <b>2/17/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory Prince Georges County, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>B 16 1958</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return to carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

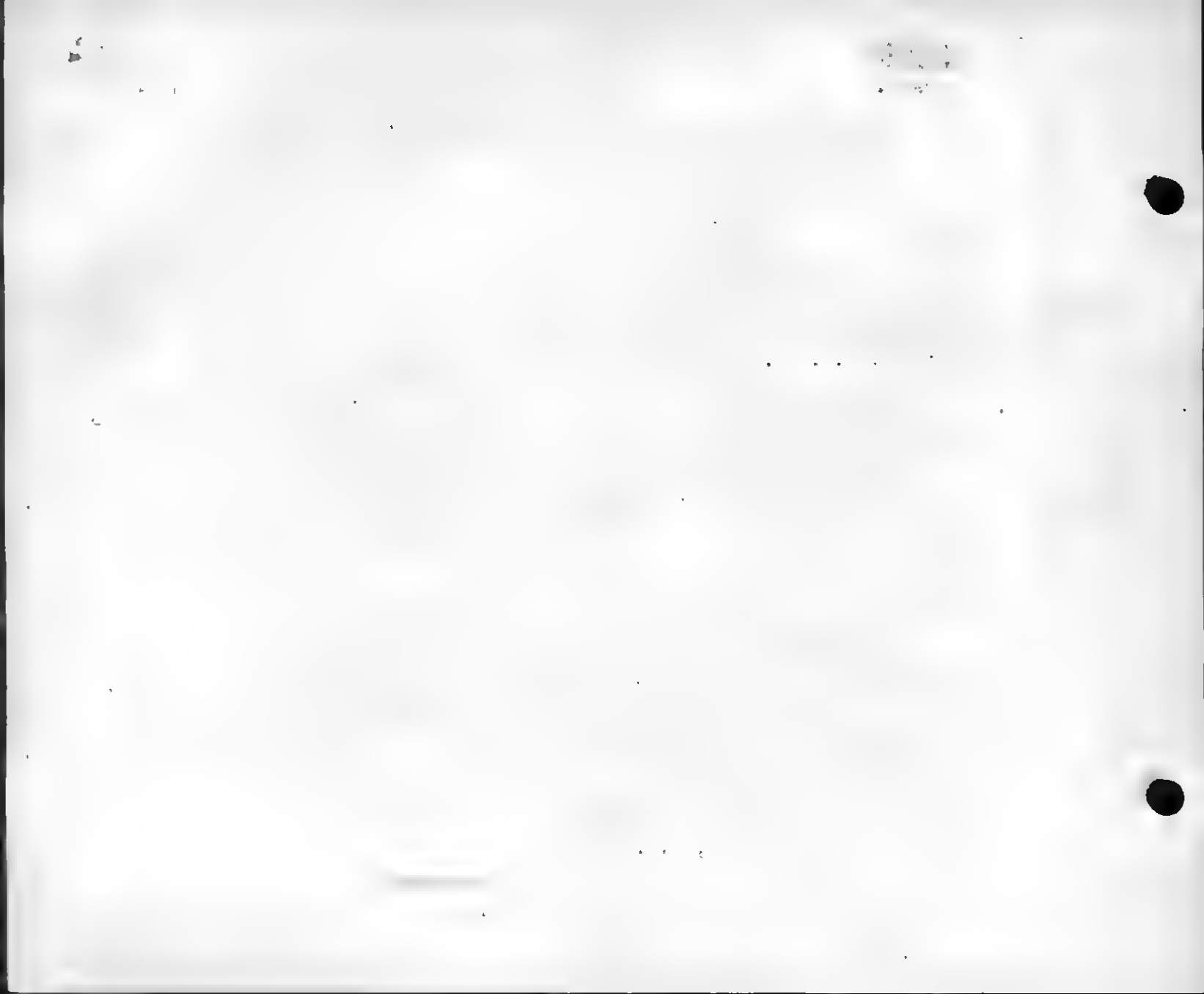
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

02459

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02416

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taorm Park</u> c. LENGTH OF STAY IN 1b <u>35 minutes</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitorium and Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Prince George</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Landover</u> d. STREET ADDRESS <u>9123 Dunbar Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph Kelly Brown</u> First Middle Last		4. DATE OF DEATH <u>2 19 19 66</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2 Dec 1929</u> 9. AGE (In years last birthday) <u>36</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Policeman, P.G. Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Ralph W Brown</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia C. Heffner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>578 42 7078</u>	
17. INFORMANT <u>Mary E Brown</u>		Address <u>Landover, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>481X</u> IMMEDIATE CAUSE (a) <u>Perforating gun shot wound of chest</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot by assailant during attempt to serve a warrant.</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>4:15 p.m.</u> <u>2 19 66</u>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Apartment building 2211 University Blvd.</u> 20f. (City or town) <u>Langley Park, P.G.Md.</u> (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Kehoe</u> EXAMINER'S NAME (Type) <u>John Kehoe, M.D.</u>		22. DATE SIGNED <u>2-20-66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1966</u>	
23c. NAME OF CEMETERY OR CREMATOR <u>Arlington National</u>		23d. LOCATION (City, town or county) <u>Arlington Virginia</u> (State) _____	
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u> DATE 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





cleaned to Medical Examiners

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

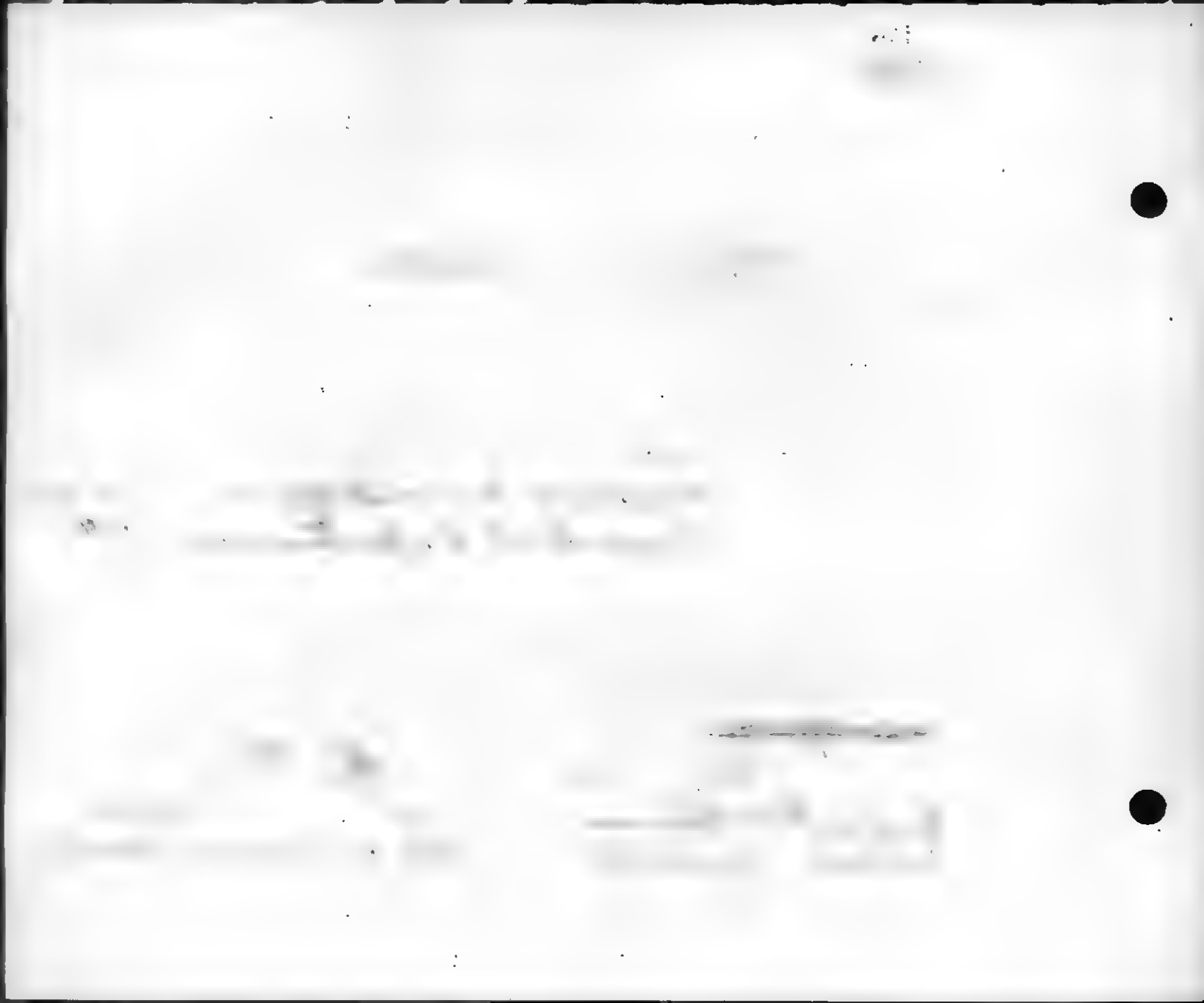
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02260

02417

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONT.</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>9 hrs 25 min</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>WASHINGTON SAN. Hosp</b>		d. STREET ADDRESS <b>BETHESDA</b>	
3. NAME OF DECEASED (Type or print) First <b>Tillie</b> Middle <b>C</b> Last <b>BROWN</b>		4. DATE OF DEATH Month <b>2</b> Day <b>12</b> Year <b>1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-6-14</b>
9. AGE (In years last birthday) <b>51</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <b>5</b> Days <b>1</b> Hours <b>1</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>WILLIAM CAFRITZ</b>		14. MOTHER'S MAIDEN NAME <b>IDA ROSLOFSKY</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>UNKNOWN</b>	
17. INFORMANT <b>PTS. RECORD</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage -</b> <b>IX</b> DUE TO (b) <b>Essential hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>10 hours</b> <b>1945</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>9:55</b> a.m. <b>2/12</b> 1966		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (i) (this hospital) attended the deceased from <b>1955</b> , to <b>2/12</b> , 1966, that (ii) (we) last saw the deceased alive on <b>2/12</b> 1966, and that death occurred at <b>9:55</b> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <b>Herbert Wechsler</b>		22b. DATE SIGNED <b>2/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert Wechsler</b>		22d. ADDRESS <b>1800 Eye St. N.W., Wash. D.C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2-14-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Bnai ISRAEL Cem.</b>		23d. LOCATION (City, town or county) (State) <b>OXON HILL, MD</b>	
24. FUNERAL DIRECTOR <b>Goldberg Funeral Home</b>		25a. REC'D BY REGISTRAR <b>4217-9th St. N.W.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>FEB 15 1966</b>	

022

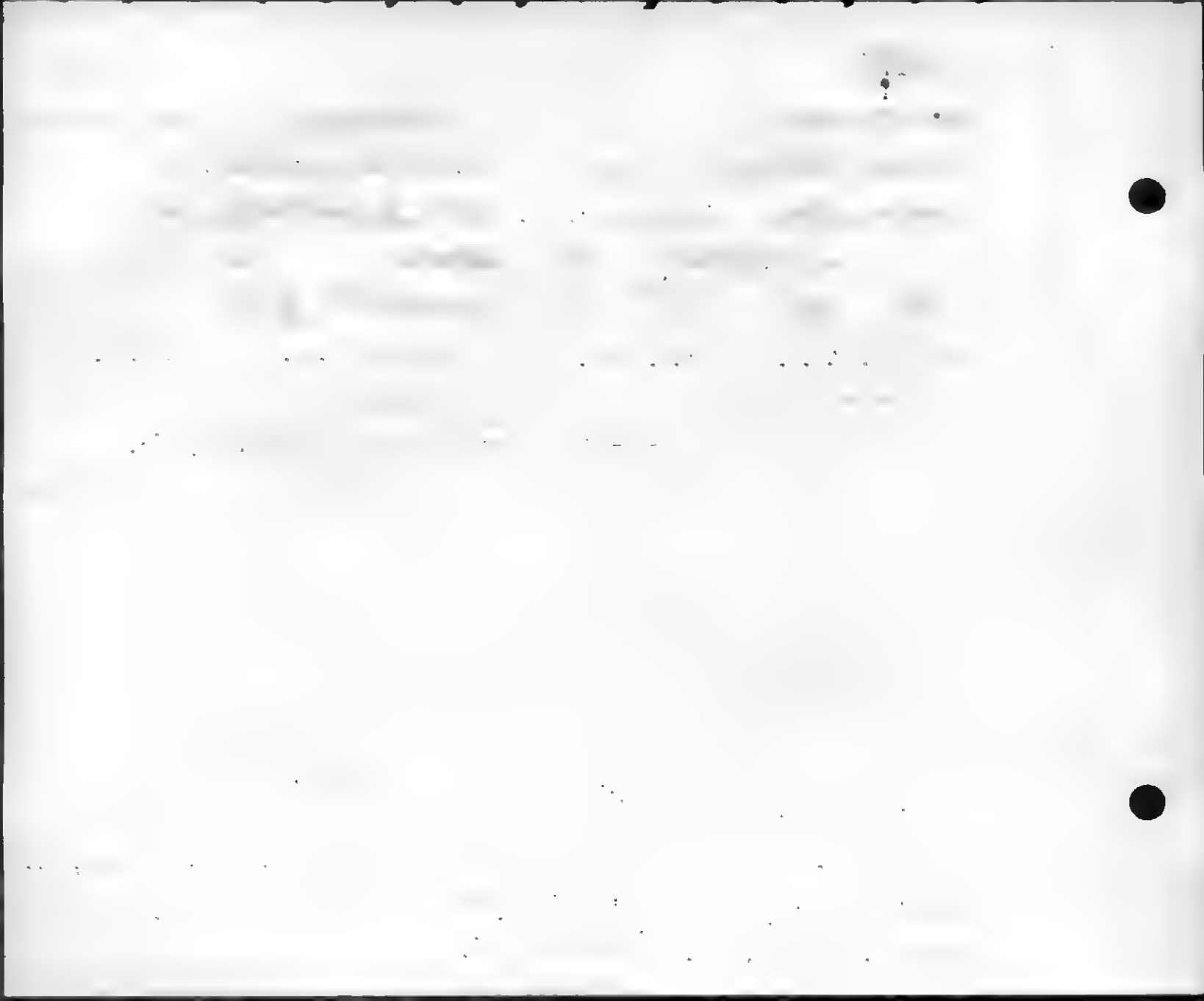


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02461 CERTIFICATE OF DEATH 02418											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN ID <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS Silver Spring, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>109 ST. LAWRENCE DR.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>JOSEPH PAUL BROWNE</u> First Middle Last						4. DATE OF DEATH <u>2</u> <u>17</u> <u>1966</u> Month Day Year					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-25-98</u> Last day of birth		9. AGE (in years last birthday) <u>68</u> yrs. If under 1 year: Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chief Admr. J.C.A.</u>						10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Martin Browne</u>						14. MOTHER'S MAIDEN NAME <u>Mary Honley</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>217-42-8429</u>		17. INFORMANT <u>Dorothy Browne</u> Address <u>109 Lawrence Dr. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of lung</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>about 6 mo</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1954</u> to <u>17 Feb</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>16 Feb</u> , 19 <u>66</u> , and that death occurred at <u>12:50 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>William D. And</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/17/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>William D. And</u>						22d. ADDRESS <u>9006 Colville Rd., Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 21 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Va.</u>		23d. LOCATION (City, town or county) (State)		25a. REC'D BY REGISTRAR <u>Warner E. Pumphrey, Inc.</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>						24c. ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

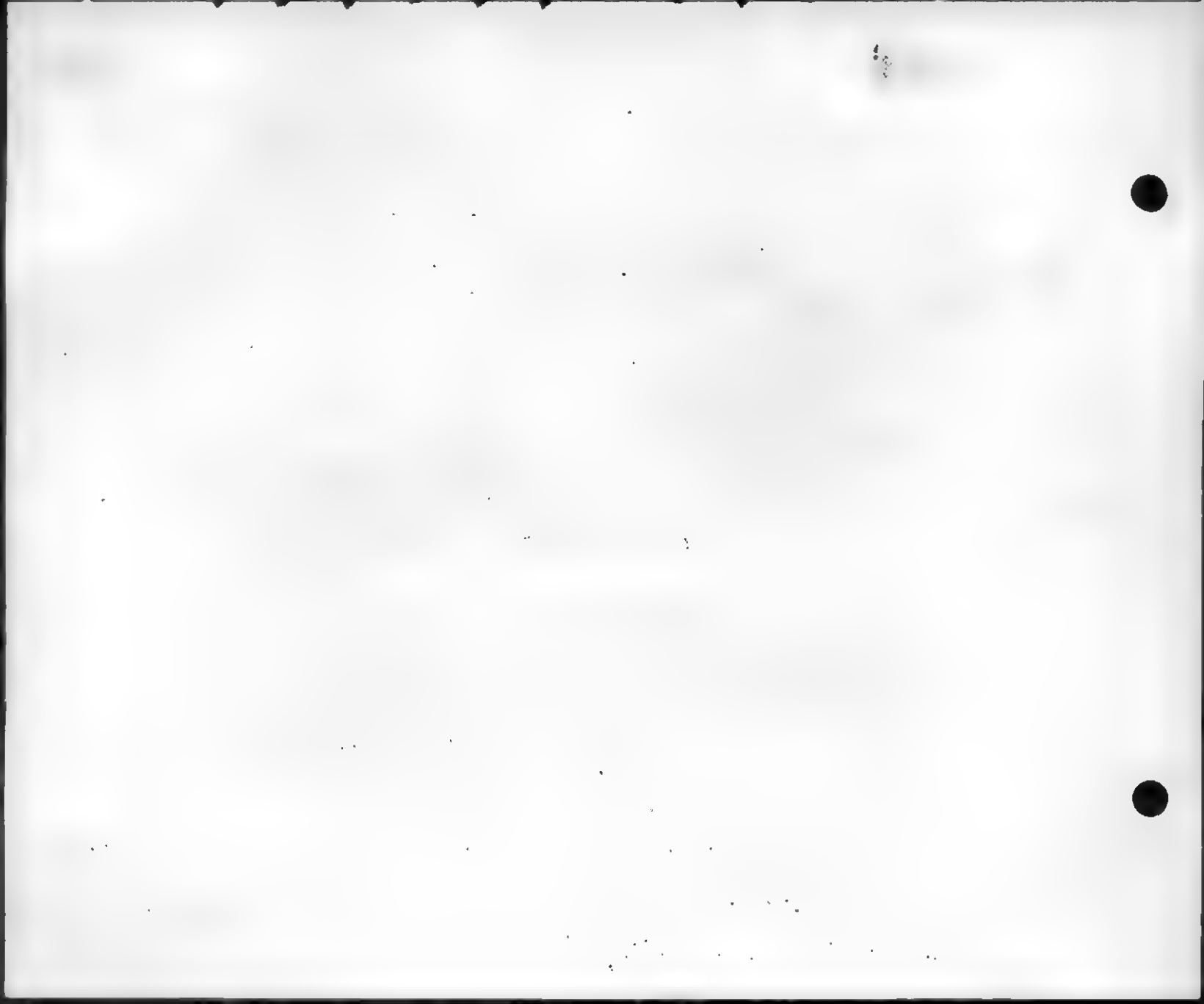


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02462		02419	
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS <b>216 Leighton Avenue</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>HAROLD LEON BUCKLEY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>White</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6-6-12</b>	
9. AGE (In years last birthday) <b>53 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRAINING SUPERVISOR D.C. TRANSIT</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Rush Buckley</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Wilkes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes give war or dates of service) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>578-10-5977</b>	
17. INFORMANT <b>Chart</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage</b> DUE TO (b) <b>Ruptured cerebral aneurysm</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>2/4</b> , 19 <b>66</b> to <b>2/8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>2/8</b> , 19 <b>66</b> , and that death occurred at <b>4:00</b> p.m. from the causes and on the date stated above.			
22a. SIGNATURE <b>R.A. Mendelsohn</b>		22b. DATE SIGNED <b>2/8</b>	
22c. PHYSICIAN'S NAME (Type) <b>R.A. MENDELSON</b>		22d. ADDRESS <b>1015 SPRING ST. SILVER SPRING MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/11/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>NATL. MEMO. PARK</b>		23d. LOCATION (City, town or county) (State) <b>FALLS CHURCH VA.</b>	
24. FUNERAL DIRECTOR <b>W.W. CHAMBERS CO</b>		25a. REC'D BY REGISTRAR <b>8633 GR. AVE. FEB 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. J. ...</b>			



1 (M)

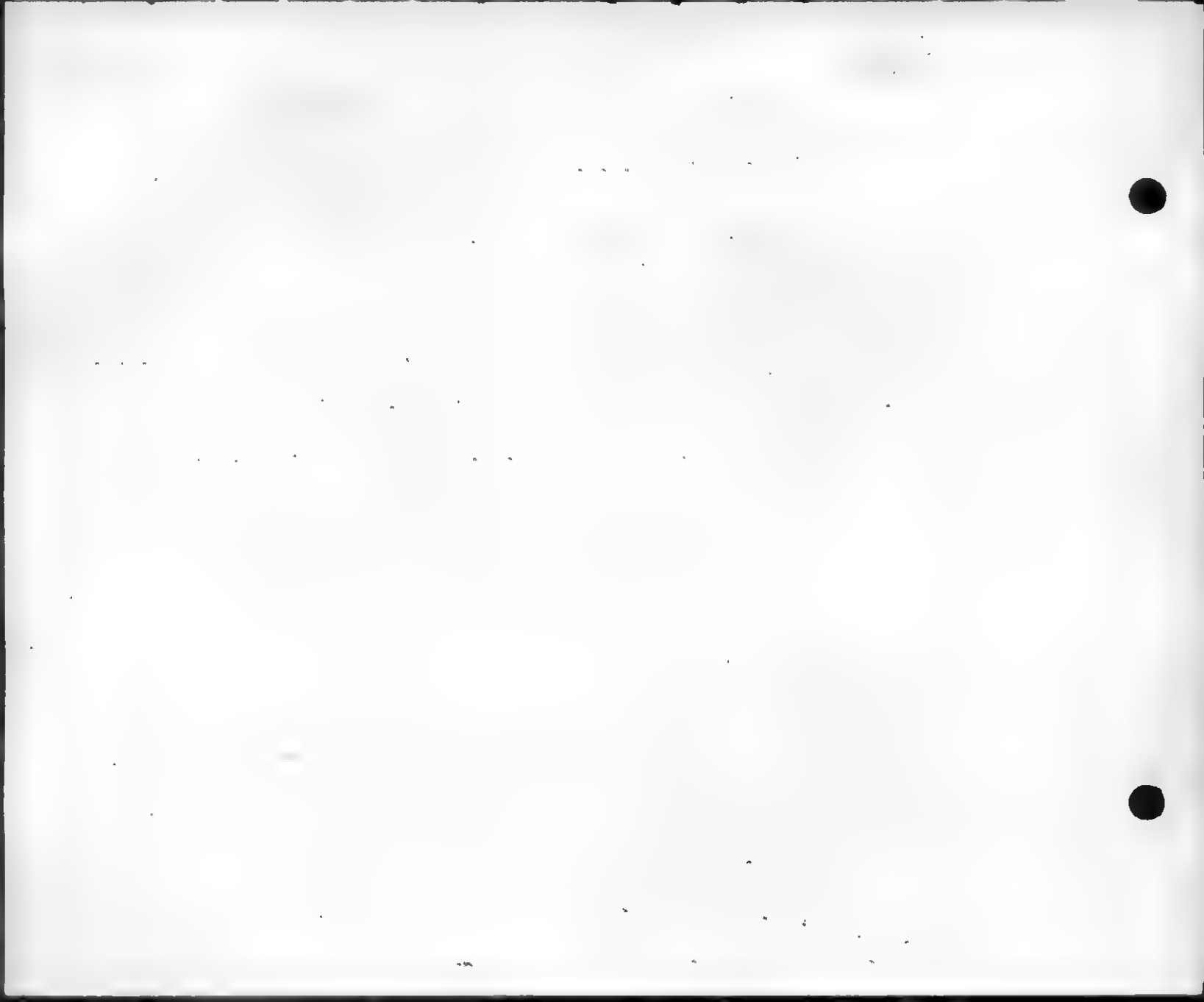
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Cleared by Dr. Kemp

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02453 CERTIFICATE OF DEATH 02420

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Md.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Carl Louis Buehl</u>		4. DATE OF DEATH <u>February 1, 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1886</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>7</u> Days <u>1</u> Hours <u>19</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired credit manager Goodyear Tire</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Doylestown, Ohio</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Louis J. Buehl</u>	
14. MOTHER'S MAIDEN NAME <u>Mary E. Snyder</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>	
16. SOCIAL SECURITY NO. <u>291-03-7652</u>		17. INFORMANT <u>J. E. Melville</u> Address <u>3706 Leather Court, Alexandria, Virginia</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> 4201 DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROSIS, GENERALIZED</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>4 HOURS</u> <u>10 YEARS</u> <u>10 YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> , 19 <u>66</u> , to <u>Jan. 31</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Jan. 31</u> , 19 <u>66</u> , and that death occurred at <u>4:00</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Philip R. James</u>		22b. DATE SIGNED <u>2-1-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Philip R. James</u>		22d. ADDRESS <u>Washington Clinic</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Feb. 3, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Silver Spring, Maryland</u>
24. FUNERAL DIRECTOR <u>James E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>8434 Georgia Avenue, Silver Spring, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>James E. Humphrey, Inc.</u>		DATE <u>FEB 7 1966</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

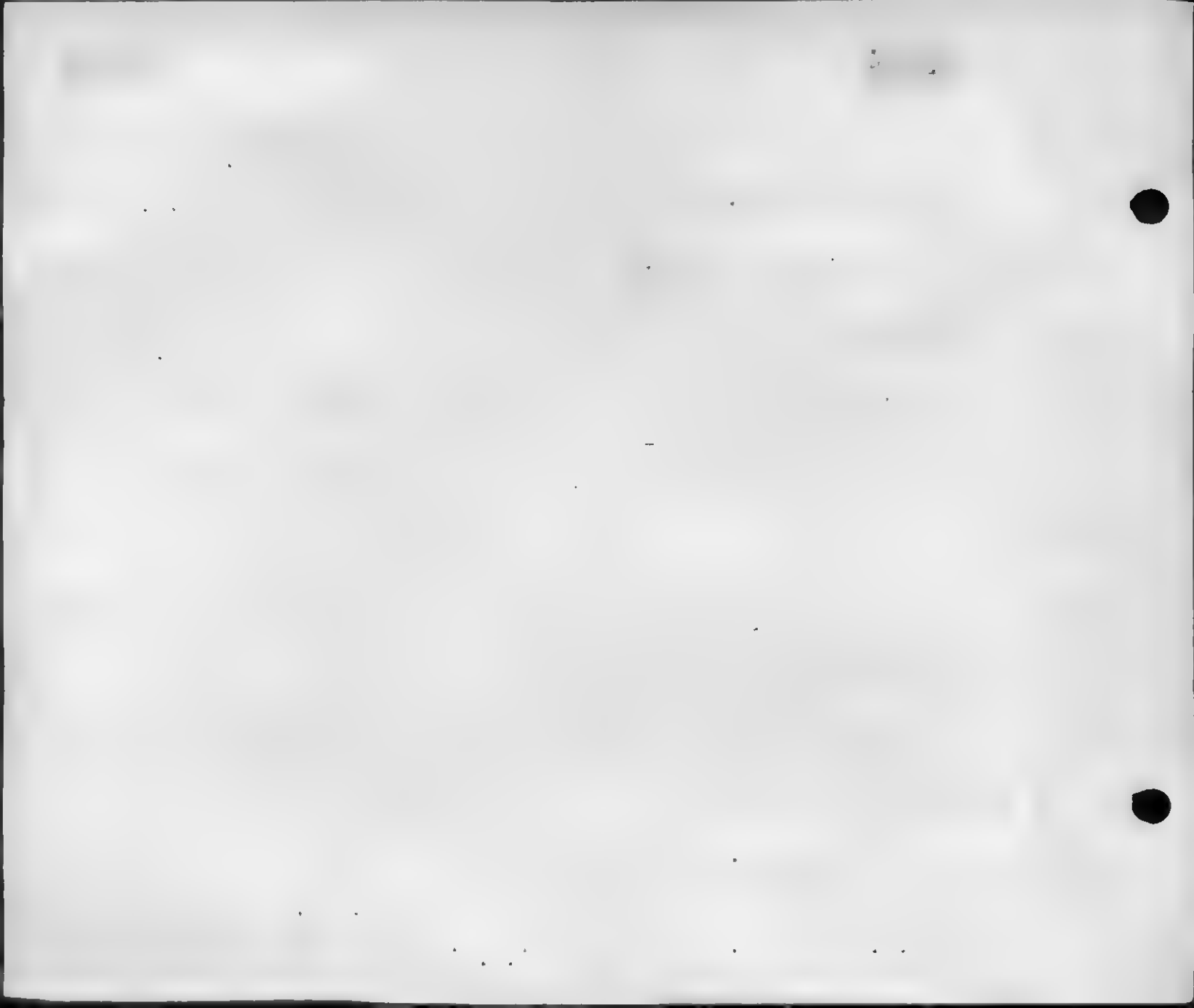
## CERTIFICATE OF DEATH

02464

02421

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>MARYLAND</b>		b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>3000 McComas Ave Kensington Gardens Sanitarium</b>		d. STREET ADDRESS <b>923 Kennedy St. N.W.</b>		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Pauline Thomason Burns</b>		4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1966</b>			
5. SEX <b>female</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>3/31/91</b>	9. AGE (in years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired school teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Illinois</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>Emil M. Thomasson</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Walstedt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>577-66-1748</b>		17. INFORMANT <b>Home Records</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Chronic lymphatic leukemia</b> <b>2040</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Page 12</b> , <b>1965</b> , to <b>Feb 11</b> , <b>1966</b> , that (I) ( <del>was</del> ) last saw the deceased alive on <b>Feb 11</b> , <b>1966</b> , and that death occurred at <b>10:28</b> P.M. from the causes and on the date stated above.					
22a. SIGNATURE <b>Seruch T. Kimble</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. 22d. ADDRESS <b>927 Pensung Rd. Silver Spring, Md.</b>		22b. DATE SIGNED <b>2-12-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Seruch T. Kimble</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE THEREOF <b>2/15/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem. Ft. Myer, Va.</b>	23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <b>The S.H. Hines Co.</b>		ADDRESS <b>2901 14th St. N.W. Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

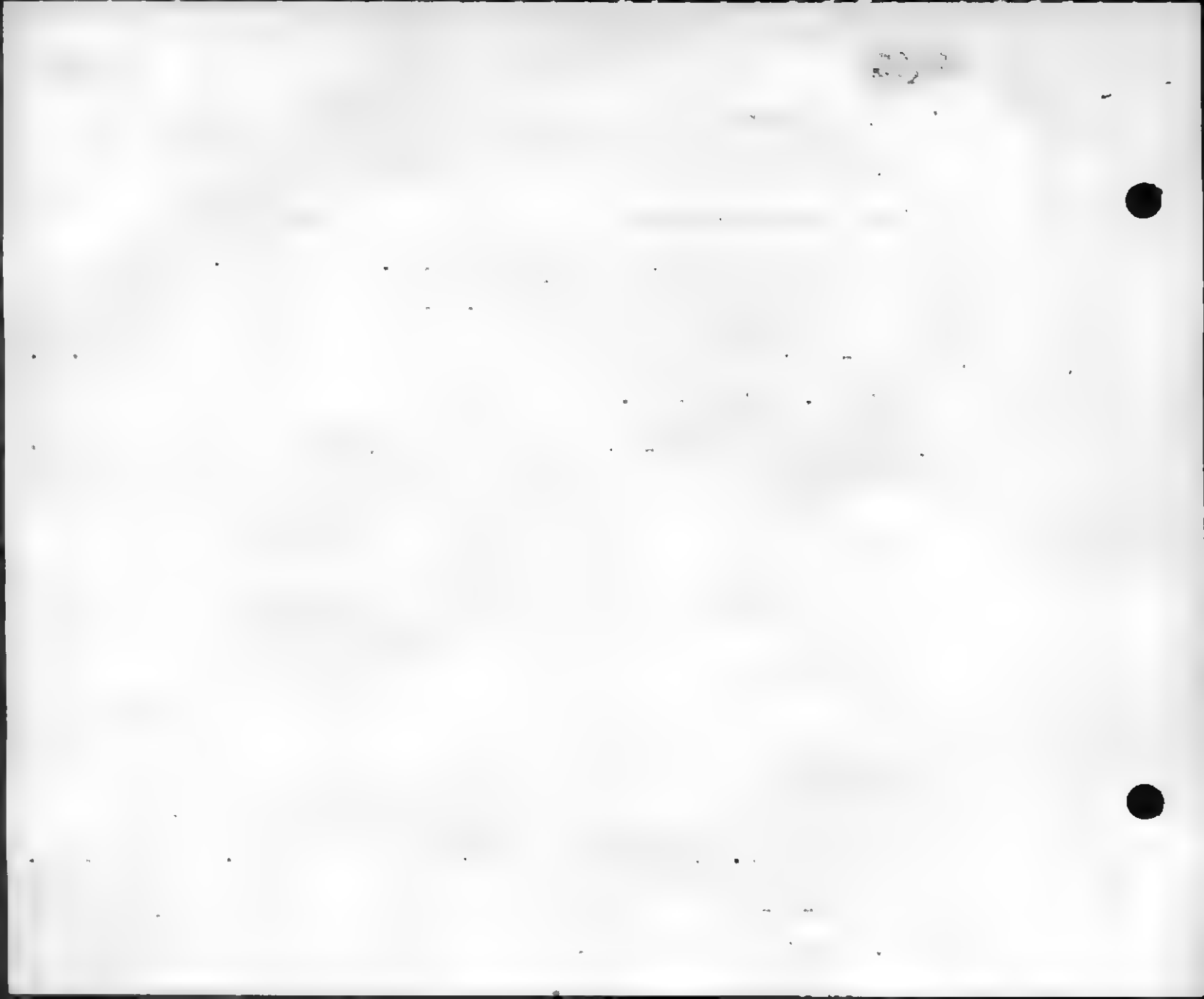
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

02465

02422

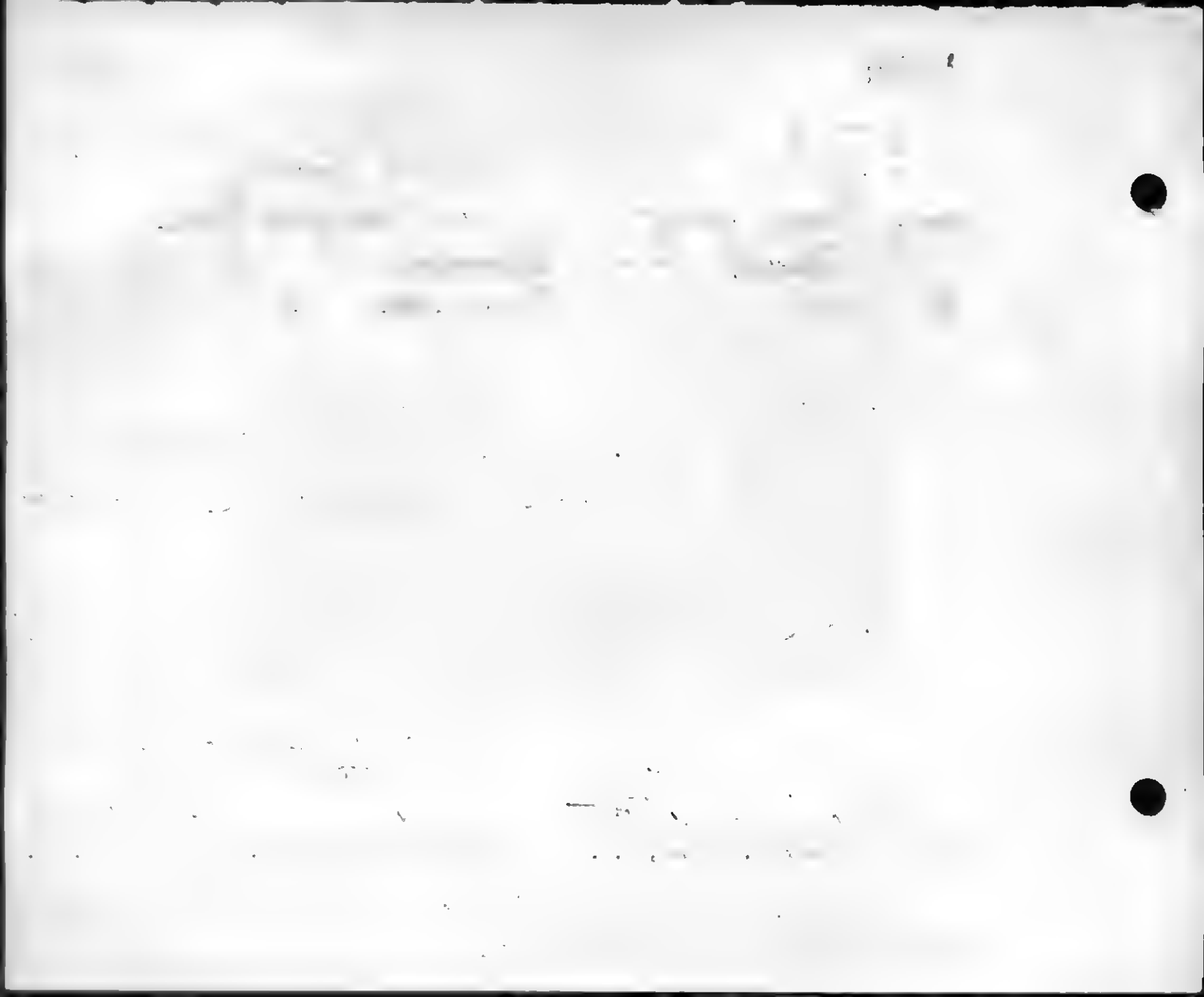
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>8313 Old Georgetown Road</b>				d. STREET ADDRESS <b>8313 Old Georgetown Road</b>			
3. NAME OF DECEASED (Type or print) First <b>AUBREY</b> Middle <b>LEWIS</b> Last <b>BURRUSS, Jr.</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>21,</b> Year <b>19 66</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 9, 1925</b>	
9. AGE (In years last birthday) <b>40</b> yrs.		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Apprentice-Electrician</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Electrical</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Richmond, Virginia</b>	
13. FATHER'S NAME <b>Aubrey L. Burruss, Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Katharine Elizabeth Toms</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes. WW II</b>				16. SOCIAL SECURITY NO. <b>230-16-9697</b>		17. INFORMANT <b>Mother</b> Address <b>Katharine E. Toms Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA BETH</b>  <b>163X</b> DUE TO  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>LUNG,</b>  DUE TO (c)</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>5 MONTH</b></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>12/29, 1965</b> to <b>2/21, 1966</b> , that (I) (we) last saw the deceased alive on <b>2/10, 1966</b> , and that death occurred at <b>8A</b> M, from the causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED <b>2-21-66</b>		22c. PHYSICIAN'S NAME (Type) <b>LEO I. DONOVAN</b>	
22d. ADDRESS <b>8218 Wisconsin Ave., Bethesda, Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>				ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>FEB 24 1966</b>	
25b. REGISTRAR'S SIGNATURE 							



## 02466

02422

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Montgomery</i>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Silver Spring</i>		c. LENGTH OF STAY IN lb <i>6 days</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Holy Cross Hosp.</i>		e. STREET ADDRESS <i>1109 Caddington Ave</i>	
3. NAME OF DECEASED (Type or print) <i>David Anthony Cameron</i>		4. DATE OF DEATH Month <i>2</i> Day <i>19</i> Year <i>1966</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 21, 1894</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>employee</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>—</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>TEXAS 46 ADIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Edward W. Cameron</i>		14. MOTHER'S MAIDEN NAME <i>Agnes B. Hendenberry</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mrs. Marie J. Ben</i>		Address <i>1109 Caddington Ave. Silver Spring, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 13, 1966</i> , to <i>Feb 19, 1966</i> , that (I) (we) last saw the deceased alive on <i>Feb 19, 1966</i> , and that death occurred at <i>125P</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Donald W. Datlow</i>		22b. DATE SIGNED <i>Feb 19, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>DONALD W. DATLOW, M.D.</i>		22d. ADDRESS <i>823 University Blvd., W., Silver Spg., Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Feb. 22, 1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>St. Patricks Cemetery</i>	23d. LOCATION (City, town or county) (State) <i>Norristown, Pennsylvania</i>
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc</i>		25a. REC'D BY REGISTRAR <i>FEB 23 1966</i>	
ADDRESS <i>8434 Georgia Avenue Silver Spring, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur Judge</i>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

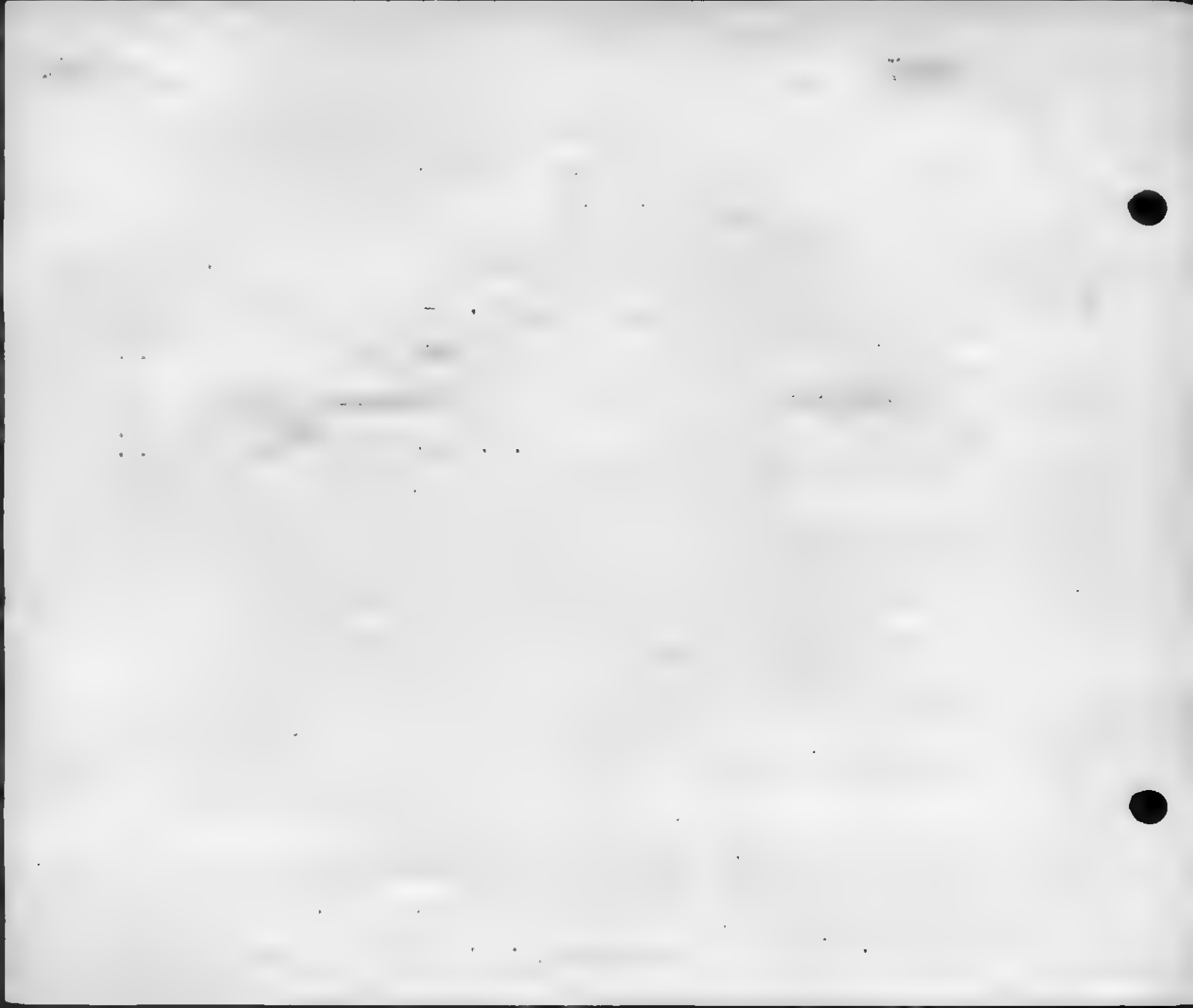
02467

02424

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>2 1/2 years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Congressional Manor Sanitarium</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Boyle</u> Last <u>Campbell</u>		d. STREET ADDRESS <u>1411 Rockville Pike</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 21-1879</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>St. John Boyle</u>		14. MOTHER'S MAIDEN NAME <u>Anna McKinley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Wm. H. Collins (Atty.)</u>		Address <u>126 Shoreham Bldg. Washington 9, D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> DUE TO (b) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10 years</u> <u>18 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive Heart Failure</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m. <u>  </u> <u>  </u> <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>
21. I certify that (I) (this hospital) attended the deceased from <u>July 1960</u> to <u>Feb. 15, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 15, 1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph H. Watson</u>		22b. DATE SIGNED <u>2-15-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph H. Watson</u>		22d. ADDRESS <u>3201 Wisconsin Ave.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	23b. DATE THEREOF <u>2/16/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bellefontaine Cem.</u>	23d. LOCATION (City, town or county) (State) <u>St. Louis, Missouri</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>The S. H. Hines Co.</u>		25a. REC'D BY REGISTRAR <u>  </u>	
ADDRESS <u>2901 14th St. N.W. Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>FEB 17 1966</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

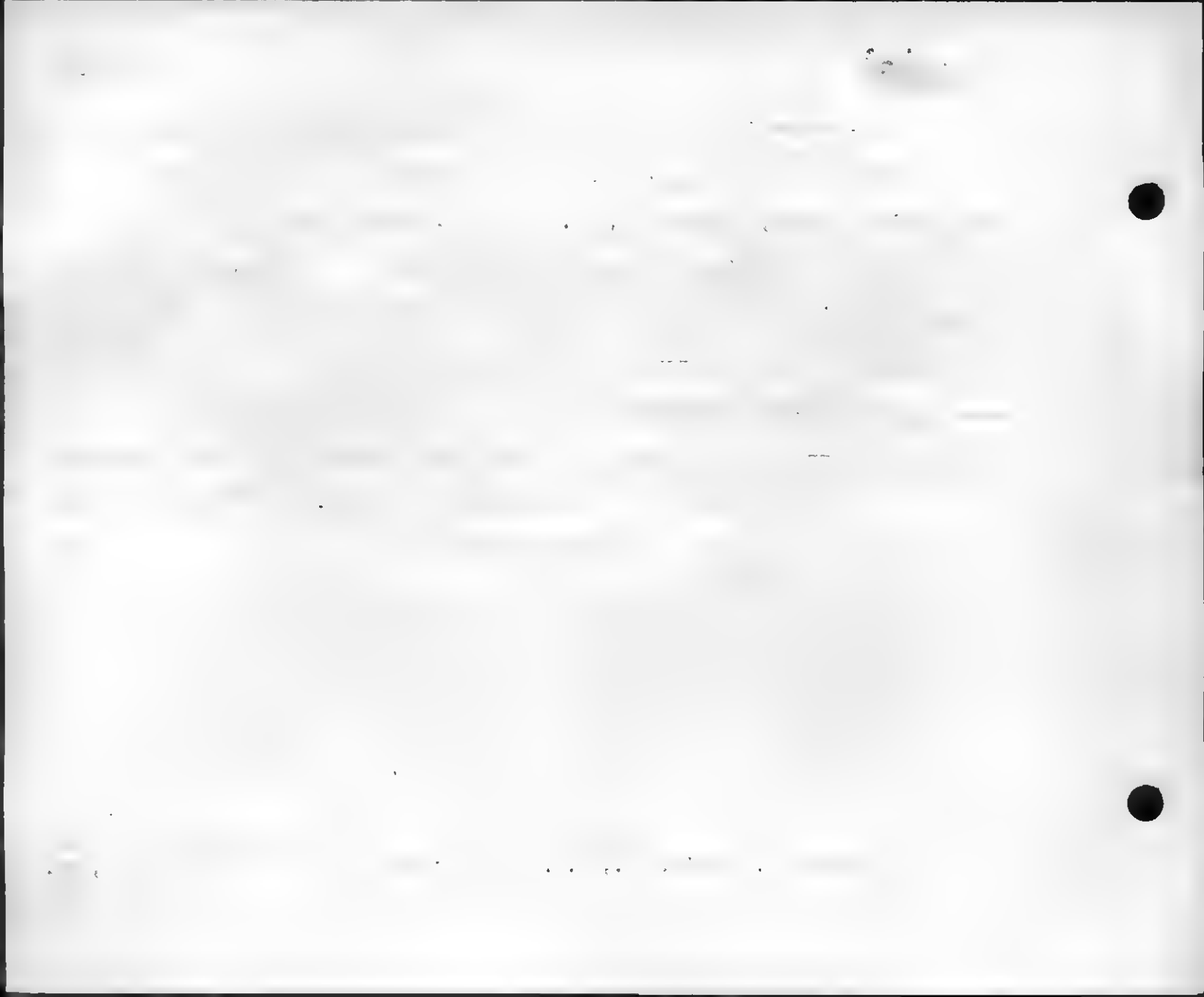
## CERTIFICATE OF DEATH

02468

02425

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN 1b <b>22 Days</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				d. STREET ADDRESS <b>3102 Shield Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Ernest</b> Last <b>Campbell</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>26 September 1956</b> 9 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		9. AGE (In years last birthday) <b>9</b> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <b>Wisconsin</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Charles Campbell</b>				14. MOTHER'S MAIDEN NAME <b>Mary Skarakis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>			
17. INFORMANT <b>The Medical Record</b>				Address <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pseudomonas meningitis and meningeal leukemia</b> DUE TO (b) <b>Acute lymphocytic leukemia</b> DUE TO (c) <b>---</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>3 1/2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>15 January</b> , 19 <b>66</b> , to <b>6 February</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 February</b> 19 <b>66</b> , and that death occurred at <b>7:55 M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Herman A. Godwin, Jr.</b> (M.D.)				22b. DATE SIGNED <b>6 February 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Herman A. Godwin, Jr., M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes Of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		23b. DATE THEREOF <b>2-8-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Blacksburg Maryland</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
ADDRESS <b>Riversdale, Md.</b>				DATE <b>FEB 10 1966</b>			

MEDICAL CERTIFICATION

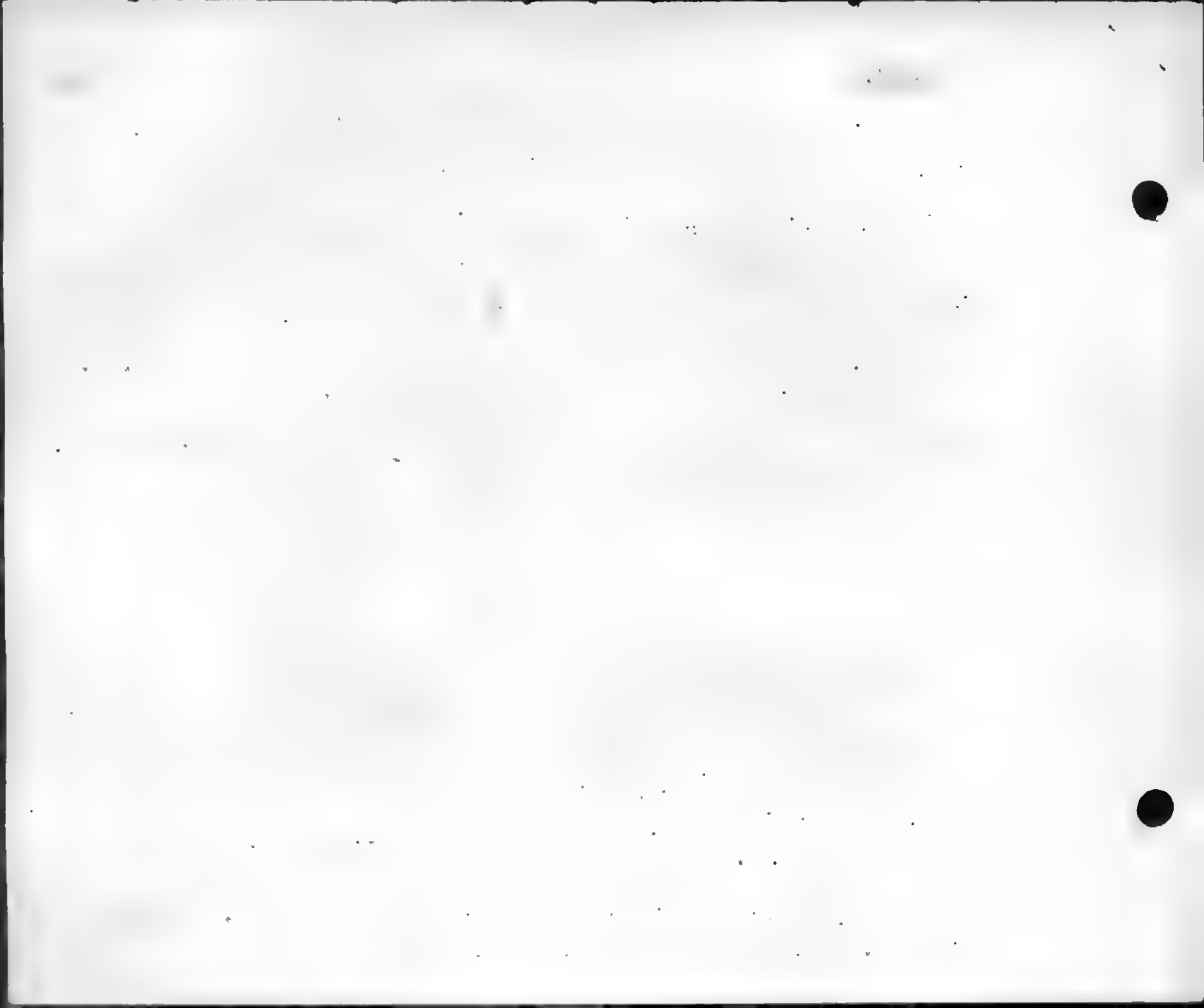


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b> c. LENGTH OF STAY IN 1b <b>2 MONTHS</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>POTOMAC VALLEY NURSING Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b> d. STREET ADDRESS <b>9509 LINDALE DRIVE</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARY</b> Middle <b>CAPEK</b> Last <b>CAPEK</b> 4. DATE OF DEATH Month <b>2</b> Day <b>18</b> Year <b>1966</b>		5. SEX <b>Female</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>2 - June - 1884</b> 9. AGE (In years last birthday) <b>81</b> yrs. 10. IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b> 10b. KIND OF BUSINESS OR INDUSTRY <b>ILLINOIS</b> 11. BIRTHPLACE (County & State, or foreign country) <b>U. S.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Matej Drije</b> 14. MOTHER'S MAIDEN NAME <b>Anna (Unknown)</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Son</b> <b>Leslie J. Capek</b> Address <b>Same as Item 2.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis Heart Disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from _____, 1966 to _____, 1966 that (I) (we) last saw the deceased alive on _____, 1966, and that death occurred at _____ M., from the causes and on the date stated above. 22a. SIGNATURE <b>PAUL D. CANTOR</b> 22b. DATE SIGNED <b>2-18-66</b> 22c. PHYSICIAN'S NAME (Type) <b>PAUL D. CANTOR</b> 22d. ADDRESS <b>4709 Montgomery Lane Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-18-66 Bohemian Natl Cemetery Chicago, Illinois</b> 23b. DATE THEREOF <b>2-18-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Bohemian Natl Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Chicago, Illinois</b>		24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b> 25a. REC'D BY REGISTRAR <b>FEB 21 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

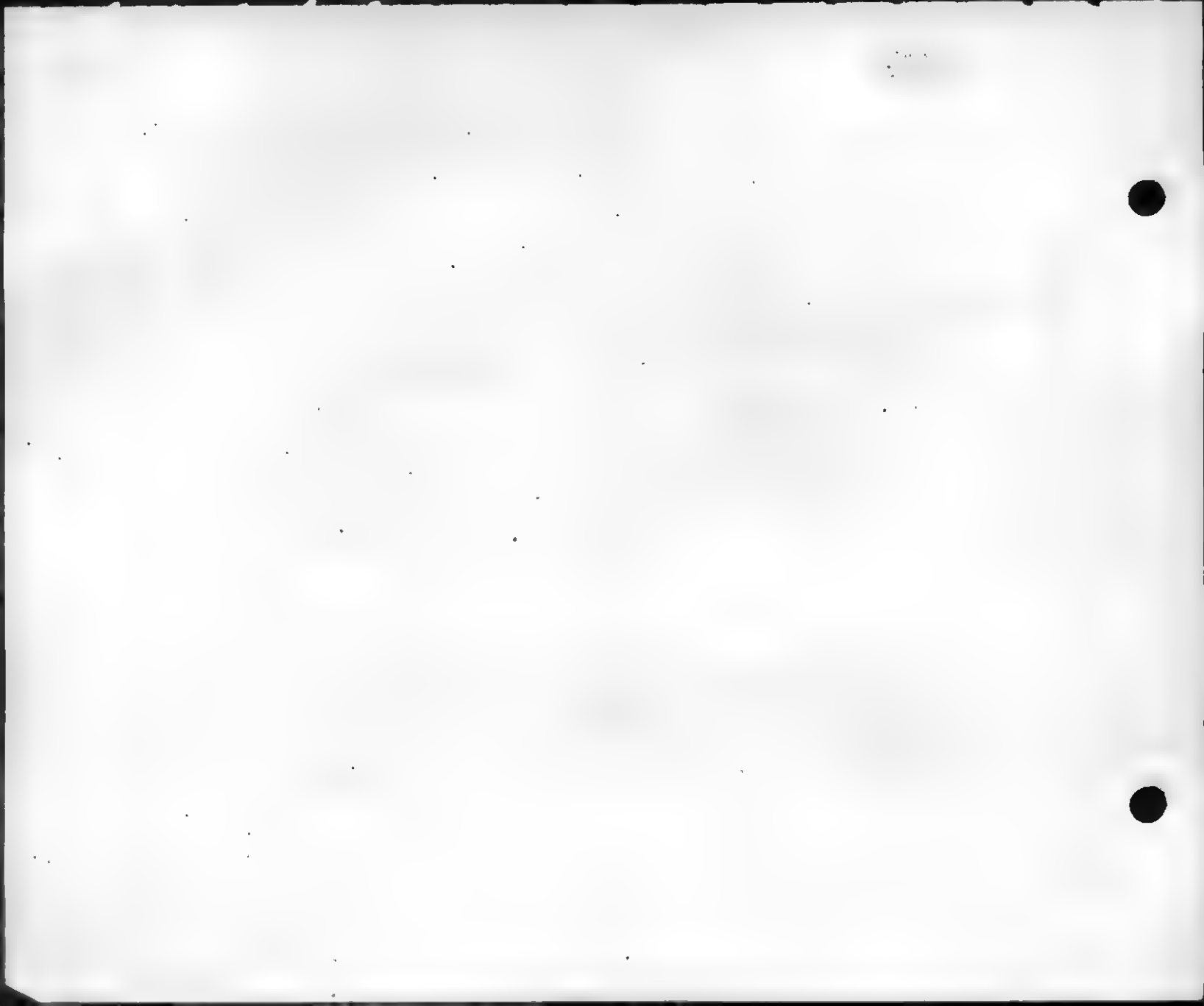


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>8 hrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. Ind. Hospital</u>				<b>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</b> a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>9310 Colesville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED (Type or print)</b> First <u>Hermon</u> Middle <u>Loma</u> Last <u>Carter</u>				<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>25</u> Year <u>1966</u>				<b>9. AGE (In years last birthday)</b> <u>87</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS: Hours <u>  </u> Min. <u>  </u>			
<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>3-10-'78</u>		<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <u>Russia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <u>Retired</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Store business</u>				<b>13. FATHER'S NAME</b> <u>David Carter</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</b> <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>294-07-5250</u>		<b>17. INFORMANT</b> <u>Tibby</u>				<b>Address</b> <u>Washington San. &amp; Hosp. Records - Takoma Park, Md.</u>	
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO (b) <u>Anterior and Posterior Cardiac infarcts</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>  </u>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>10 months</u> <u>3 1/2 years</u>	
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>											
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</b>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from <u>April 14</u>, 19<u>62</u>, to <u>Feb 25</u>, 19<u>66</u>, that (I) (we) last saw the deceased alive on <u>Feb 24</u>, 19<u>66</u>, and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <u>John N. Andrews</u>				<b>22b. DATE SIGNED</b> <u>Feb. 25-66</u>				<b>22c. ADDRESS</b> <u>1601 Colesville Rd Silver Spring Md.</u>			
<b>22d. PHYSICIAN'S NAME (Type)</b> <u>John N Andrews</u>				<b>22e. ADDRESS</b> <u>1601 Colesville Rd Silver Spring Md.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3/1/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NAT'L MEM. PARK</u>		<b>23d. LOCATION (city, town or county) (State)</b> <u>Falls Church, VA</u>			
<b>24. FUNERAL DIRECTOR</b> <u>W.W. CHAMBERS, Inc</u>				<b>ADDRESS</b> <u>512 5th MD</u>				<b>25a. REC'D BY REGISTRAR</b> <u>MAR 2 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exempted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

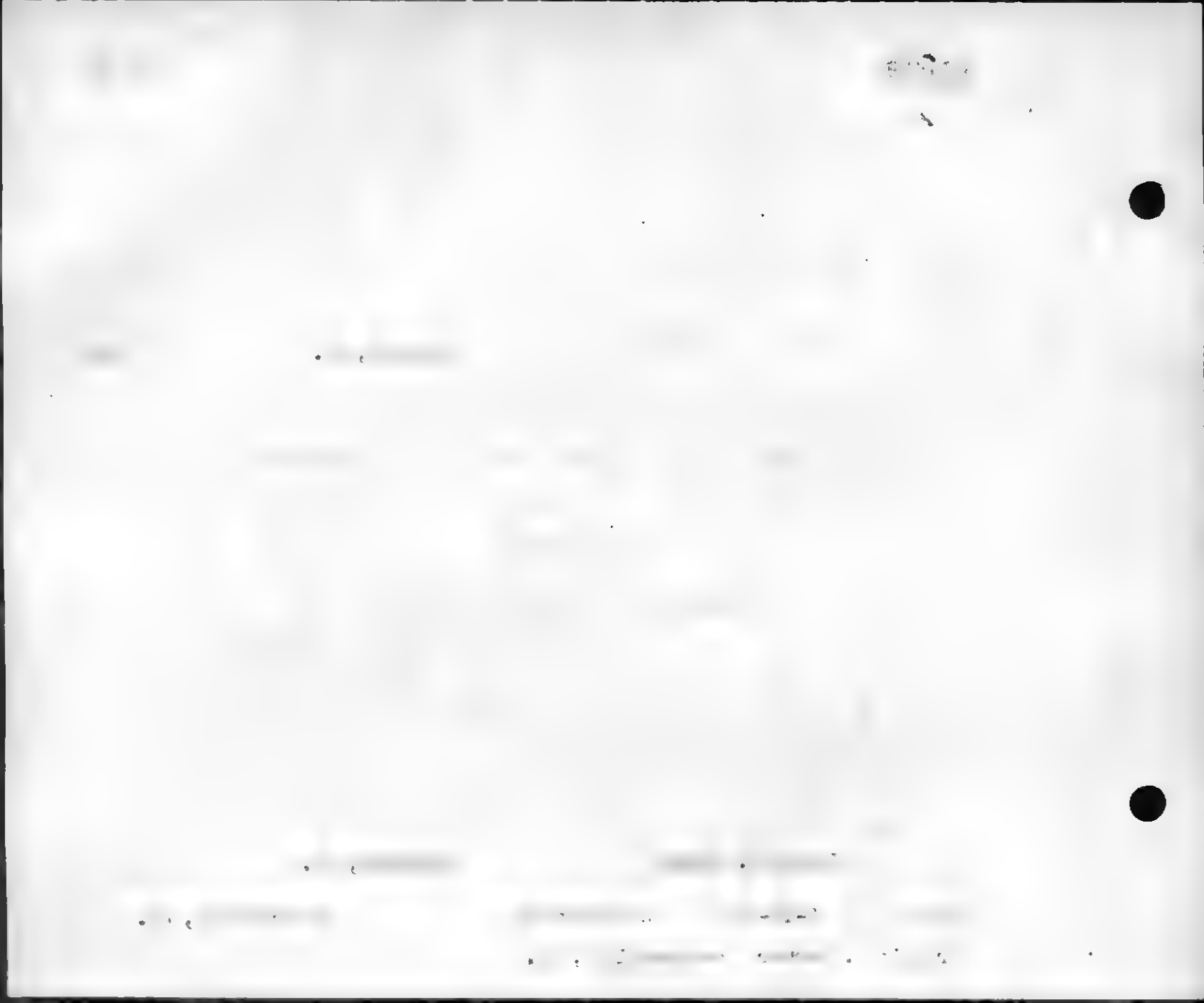
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02471

02428

1. PLACE OF DEATH e. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bermentown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				d. STREET ADDRESS <u>Box 126 Berryville Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Patrick <del>Ray</del> Alan Carter</u>				4. DATE OF DEATH <u>2</u> <u>16</u> <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-14-66</u>	
9. AGE (in years last birthday) <u>32</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>2</u> Hours <u>32</u> Min.		11. BIRTHPLACE (County & State, or foreign country) <u>Bethesda, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME <u>Walter Delmare Carter</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn Kathryn Streat</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Birth Certificate</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> DUE TO (b) <u>Pneumaturia</u> DUE TO (c) <u>Pneumaturia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-14</u> , 19 <u>66</u> , to <u>2-16</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-16</u> , 19 <u>66</u> , and that death occurred at <u>12:45</u> P.M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph A. Dugan</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>3/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Joseph A. Dugan</u>				22d. ADDRESS <u>Bethesda, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Laytonsville</u>		23d. LOCATION (City, town or county) (State) <u>Laytonsville, Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> <u>Laytonsville, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/60

(M)

02472

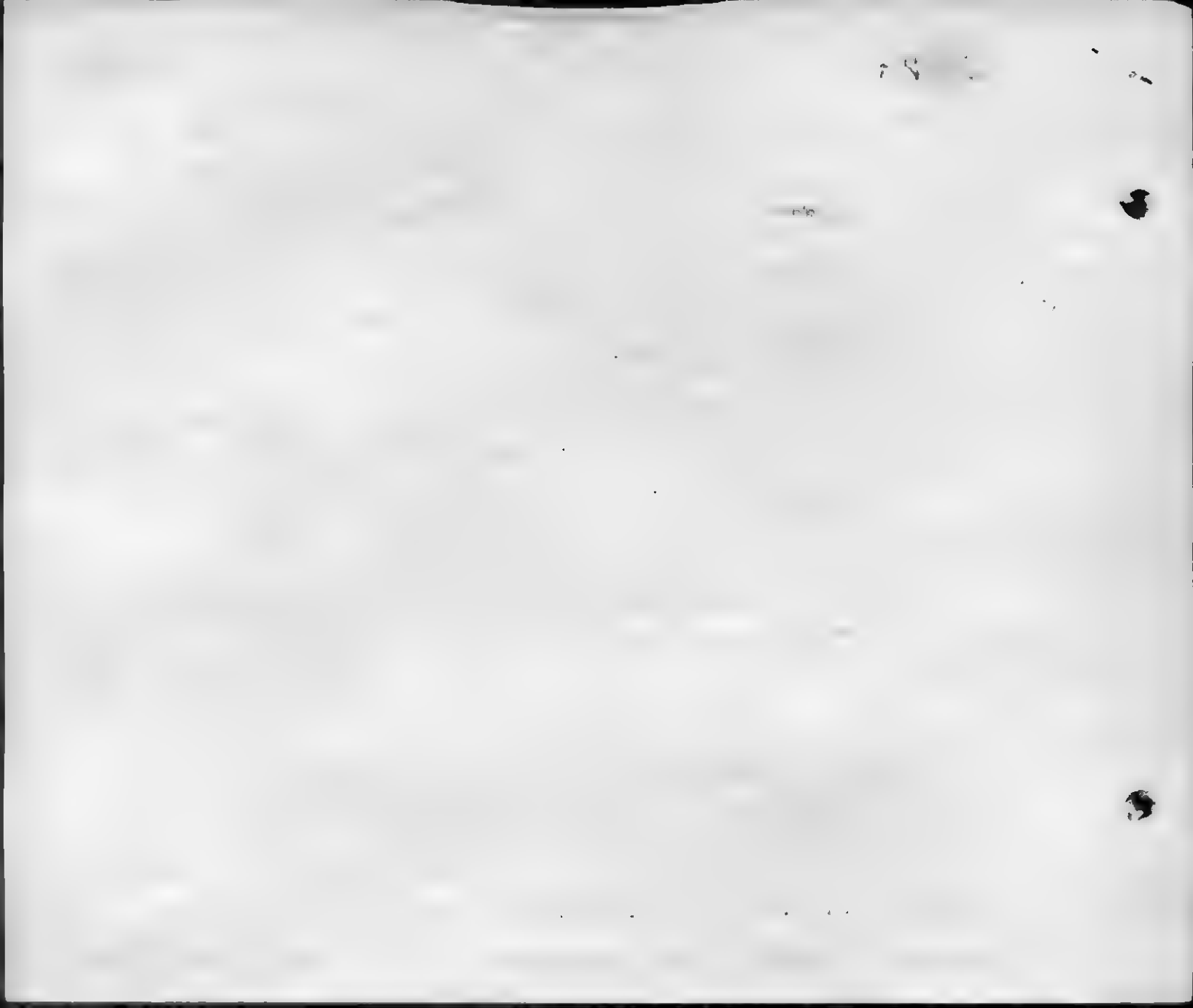
# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

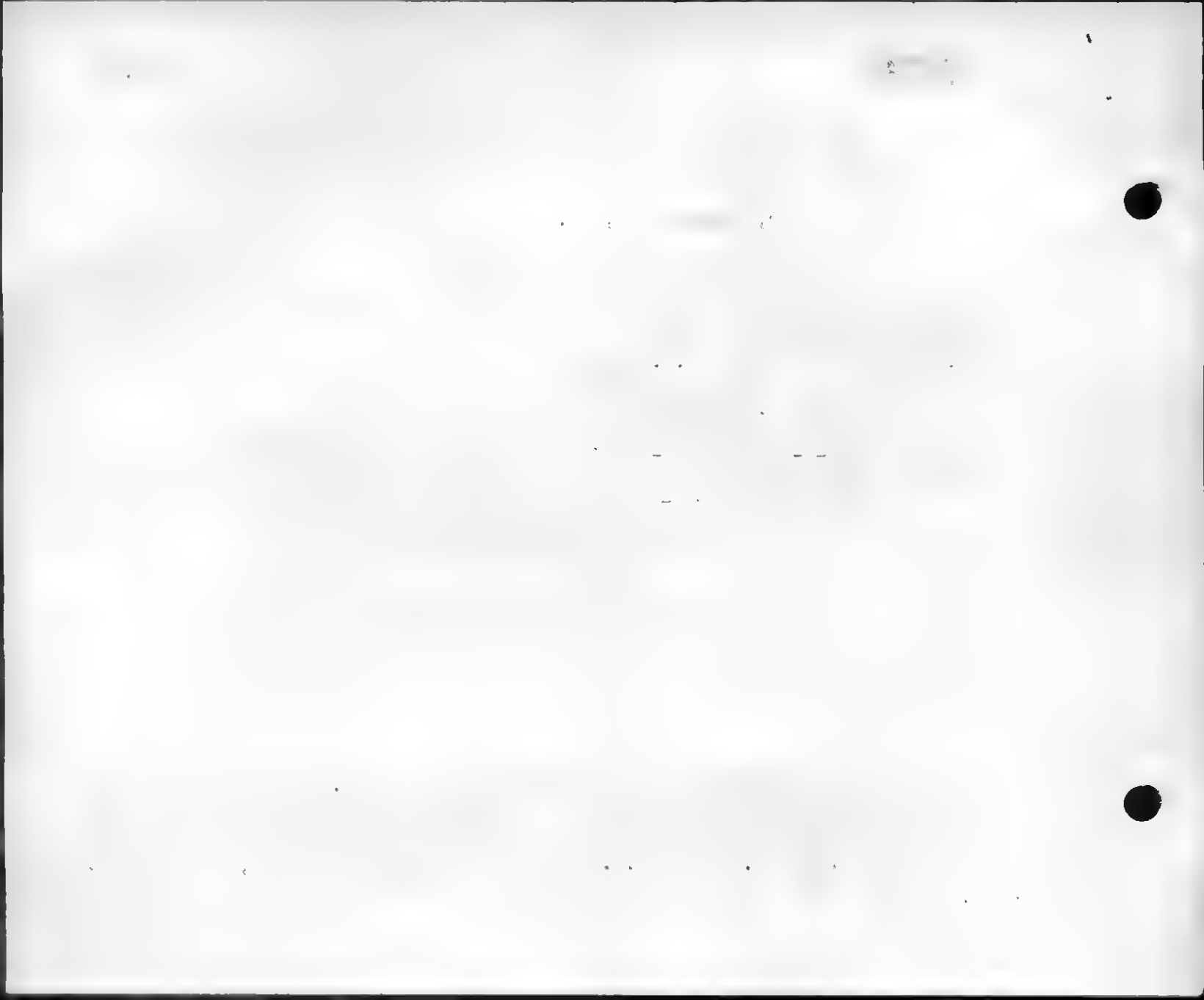
02429

<p>1. PLACE OF DEATH</p> <p>a. COUNTY <b>Montgomery</b></p> <p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b></p> <p>c. LENGTH OF STAY IN b <b>12 yrs.</b></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>9600 Forest Road</b></p>		<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)</p> <p>a. STATE <b>Maryland</b></p> <p>b. COUNTY <b>Montgomery</b></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b></p> <p>d. STREET ADDRESS <b>9600 Forest Road</b></p>	
<p>3. NAME OF DECEASED (Type or print) <b>Catharine</b></p> <p>5. SEX <b>F</b></p> <p>6. COLOR OR RACE <b>W</b></p> <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> D.VORCED <input type="checkbox"/></p> <p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Education</b></p> <p>13. FATHER'S NAME <b>Donis C. Catrough</b></p>		<p>4. DATE OF DEATH <b>February 23 1966</b></p> <p>8. DATE OF BIRTH <b>April 5, 1913</b></p> <p>9. AGE (In years last birthday) <b>72</b> yrs. IF UNDER 1 YEAR: Months <b>10</b> Days <b>15</b> IF UNDER 24 HRS.: Hours <b>15</b> Min.</p> <p>10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b></p> <p>11. BIRTHPLACE (County &amp; State, or foreign country) <b>St. Louis, Mo.</b></p> <p>12. COUNTRY OF WHAT COUNTRY <b>U.S.A.</b></p> <p>14. MOTHER'S MAIDEN NAME <b>Ursaline Convent</b></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)</p> <p>16. SOCIAL SECURITY NO <b>None</b></p> <p>17. INFORMANT <b>Ursaline Convent</b></p>		<p>18. CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))</p> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOVASCULAR DISEASE</b></p> <p>4201 DUE TO <b>THROMBOSIS OF CORONARY ARTERY</b></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIO-SCLEROTIC HEART DISEASE</b></p> <p>DUE TO (c) <b>4201</b></p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>CARCINOMA (R) BREAST 10 YEARS</b></p> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)</p> <p>20c. TIME OF INJURY Month, Day, Year <b>19</b></p> <p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p> <p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b></p> <p>20f. (City or town) (County) (State)</p>		<p>21. I certify that (I) (this hospital) attended the deceased from <b>FEB. 10, 1953</b> to <b>FEB. 24, 1966</b>, that (I) (we) last saw the deceased alive on <b>FEB. 10, 1966</b>, and that death occurred at <b>6 A.M.</b> from the causes and on the date stated above.</p> <p>22a. SIGNATURE <b>Charles Judge</b></p> <p>22b. DATE SIGNED <b>2-24-66</b></p> <p>22c. PHYSICIAN'S NAME (Type) <b>DR. CHARLES JUDGE</b></p> <p>22d. ADDRESS <b>1000 15th St. N.W. Washington, D.C.</b></p>	
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p> <p>23b. DATE THEREOF <b>2/26/66</b></p> <p>23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b></p> <p>23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b></p>		<p>24. FUNERAL DIRECTOR'S SIGNATURE <b>ROBERT A. PUMPHREY</b></p> <p>25a. REC'D BY REGISTRAR <b>MAR 2 1966</b></p> <p>25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b></p>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02473					02430				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <b>Montgomery</b>					a. STATE <b>Maryland</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>					b. COUNTY <b>Prince Georges</b>				
c. LENGTH OF STAY IN ID <b>93 Days</b>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>					d. STREET ADDRESS <b>Box 257, Route #1</b>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <b>Mary</b> Middle <b>Ann</b> Last <b>Chapman</b>					Month <b>February</b> Day <b>23</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 November 1942</b>		9. AGE (in years last birthday) <b>23</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Typist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (County, State, or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John A. Chapman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-40-6596</b>		17. INFORMANT <b>The Medical Record</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jennifer</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram-negative Septicemia</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <b>Acute Lymphocytic Leukemia</b> DUE TO (c) <b>20 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <b>XX</b> (this hospital) attended the deceased from <b>22 November, 19 65</b> , to <b>23 February 66</b> , that <b>X</b> (we) last saw the deceased alive on <b>23 February 19 66</b> , and that death occurred at <b>12:20 P.M.</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>James H. Wells</b>		22b. DATE SIGNED <b>23 February 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>James H. Wells, M.D.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	
23b. DATE THEREOF <b>2-26-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARY'S</b>		23d. LOCATION (City, town or county) (State) <b>BRANTOWN Md</b>		25a. REC'D BY REGISTRAR <b>FEB 28 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	
24. FUNERAL DIRECTOR <b>HUNTT FUNERAL HOME</b>		ADDRESS <b>WALDORF MD</b>		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and on or after 72 hours after death.

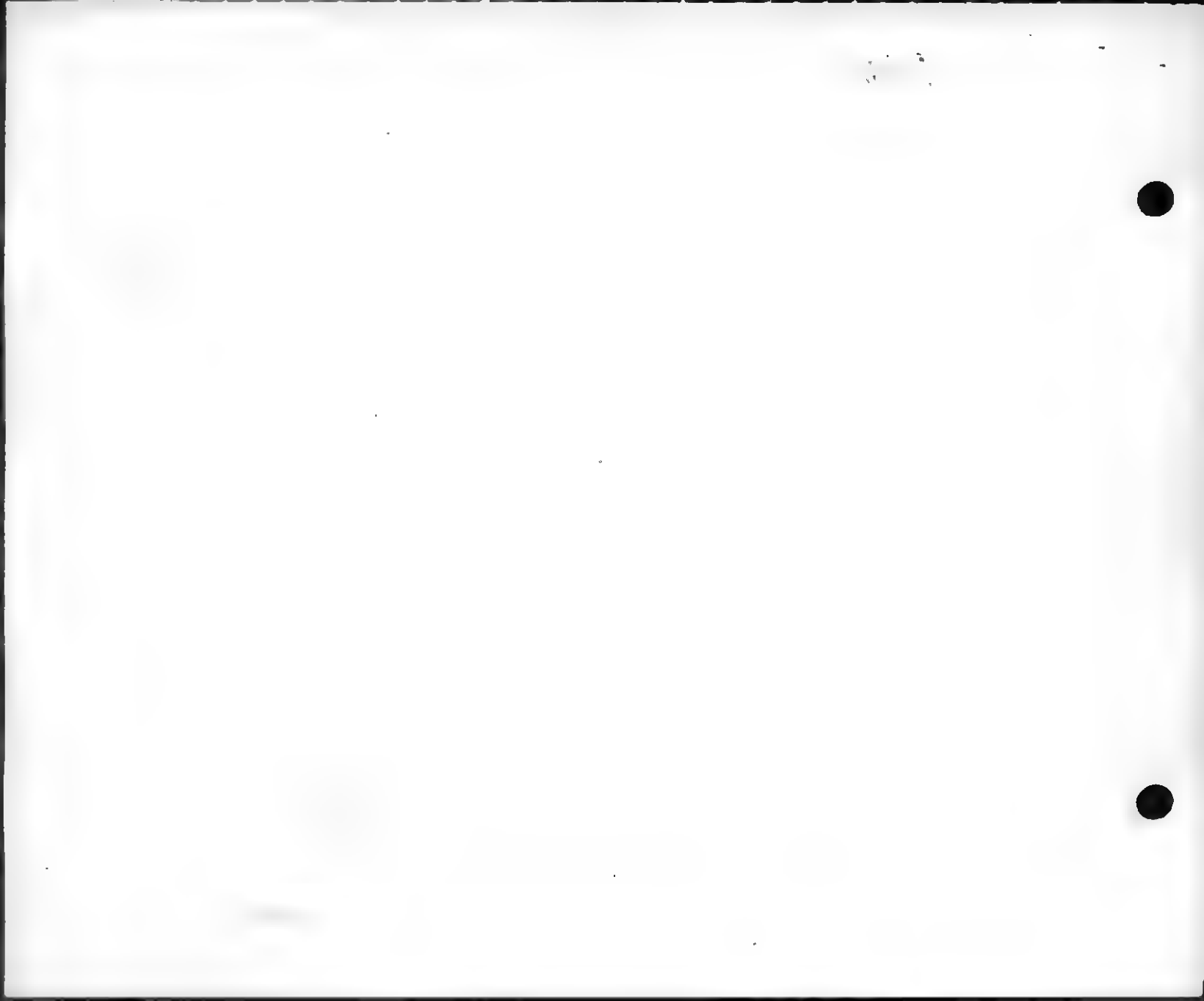
FOR STATE HEALTH DEPT.

02474

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02431

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived f institution Residence before admission) a. STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c LENGTH OF STAY IN 1b <u>23 days</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>John</u> Last <u>Chester</u>		4. DATE OF DEATH Month <u>February</u> Day <u>28</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>July 23, 1880</u>
9. AGE (In years lost birthday) <u>85</u> yrs		F UNDER 1 YEAR Months <u>  </u> Days <u>  </u> F UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter (retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter for National Zoological</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>US</u>	
13 FATHER'S NAME <u>Unknown</u>		14 MOTHER'S MAIDEN NAME <u>UnKnown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>579-34-7281</u>	
17 INFORMANT <u>Patient's chart, admission record</u>		Address <u>  </u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary embolism, secondary to fracture, 9030</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>right femur, due to fall</u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased became dizzy and fell from chair to floor</u>	
20c TIME OF INJURY Month Day, Year <u>3:00 p.m. 1/26 1966</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (home, farm, factory, street, office bldg., etc.) <u>Home</u>
20f (City or town) <u>Kensington</u> (County) <u>Montg.</u> (State) <u>Md.</u>		21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Belden R. Reap, M.D.</u>		22. DATE SIGNED <u>Febr. 28, 1966</u>	
EXAMINER'S NAME (Type) <u>Belden R. Reap, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>3/3/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d LOCATION (City or Town) (County) (State) <u>Suitland Maryland</u>	
24 FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		25a REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>MAR 3 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c REGISTRAR'S NAME <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

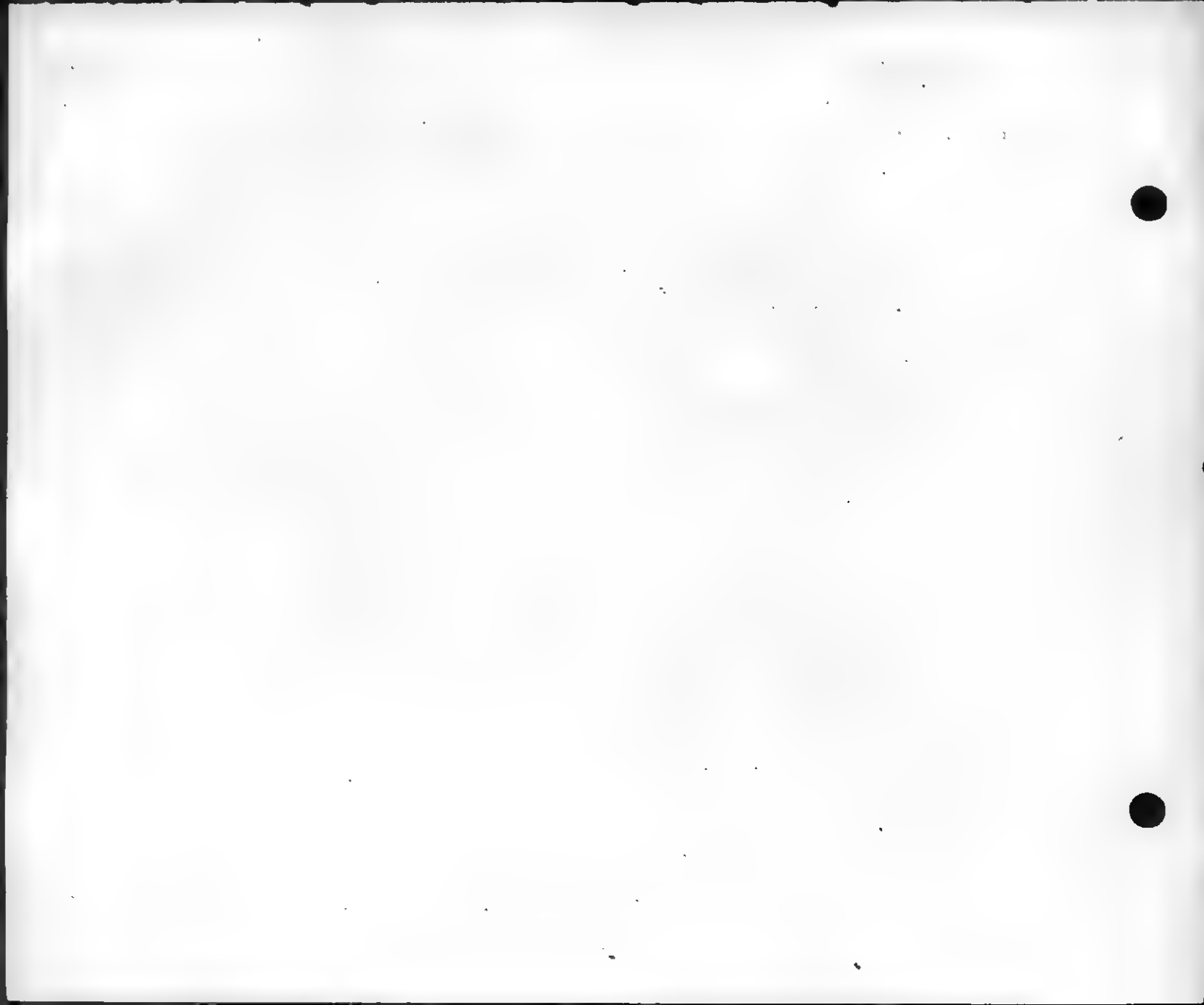
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02475

02432

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Laurel</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Box 265 Rt #2</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Sally Loe Christian</u> First Middle Last				4. DATE OF DEATH Month <u>2</u> - Day <u>13</u> Year <u>1966</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-3-1903</u> 62 yrs.	
9. AGE (In years last birthday)		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Arnold</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Carroll</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>L Hodgkin disease</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/9/66</u> , 19 <u>66</u> , to <u>2/13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>66</u> , and that death occurred at <u>4:25</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Raymond O. Lewis</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-16-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sanage Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Sanage Md.</u>	
24. FUNERAL DIRECTOR <u>DeWitt Donaldson</u>				25a. RECEIVED BY REGISTRAR <u>Charles J. ...</u> 25b. REGISTRAR'S SIGNATURE DATE <u>FEB 28 1966</u>			





1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

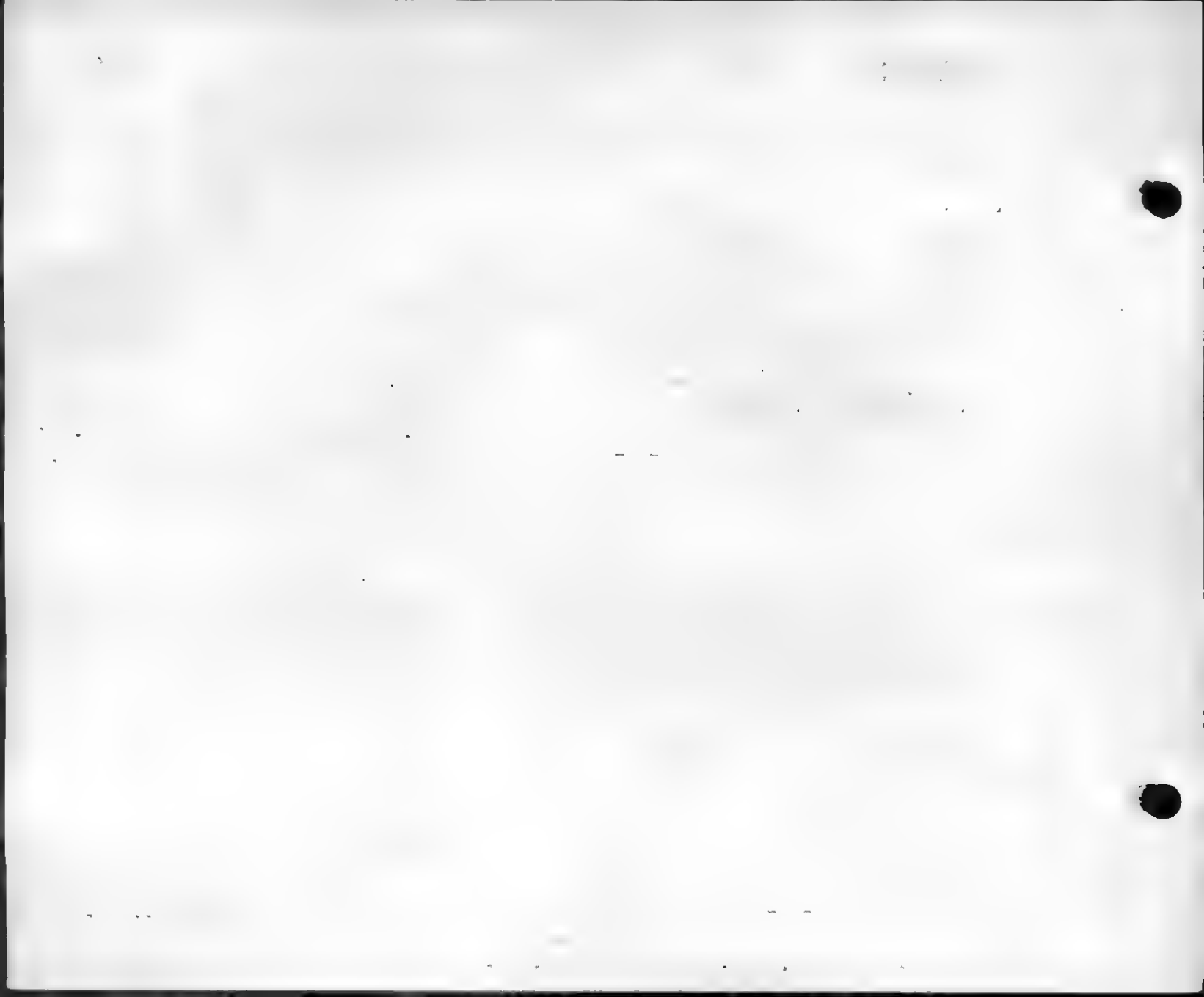
02476

02433

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>10 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8100 Tahoma Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>Jessie May Clark</u>		4. DATE OF DEATH <u>2 - 15 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>09 6-17-1901</u>		9. AGE (In years last birthday) <u>55 6 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>				11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Andrew Blair Thomas</u>				14. MOTHER'S MAIDEN NAME <u>Nellie May Howard</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>None</u>							
16. SOCIAL SECURITY NO. <u>578-26-8455</u>				17. INFORMANT <u>Mrs. Russell Brigham</u> Address <u>1034 Univ. Blvd. Silver Spring, Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <u>Belden R. Reap</u>				M.D. <u>BELDEN R. REAP M.D.</u>				22. DATE SIGNED <u>2-16-1966</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>				Address (Street, city, town, or county) <u>Silver Spring, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2-18-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PWS. Page 5 may be retained for your files.

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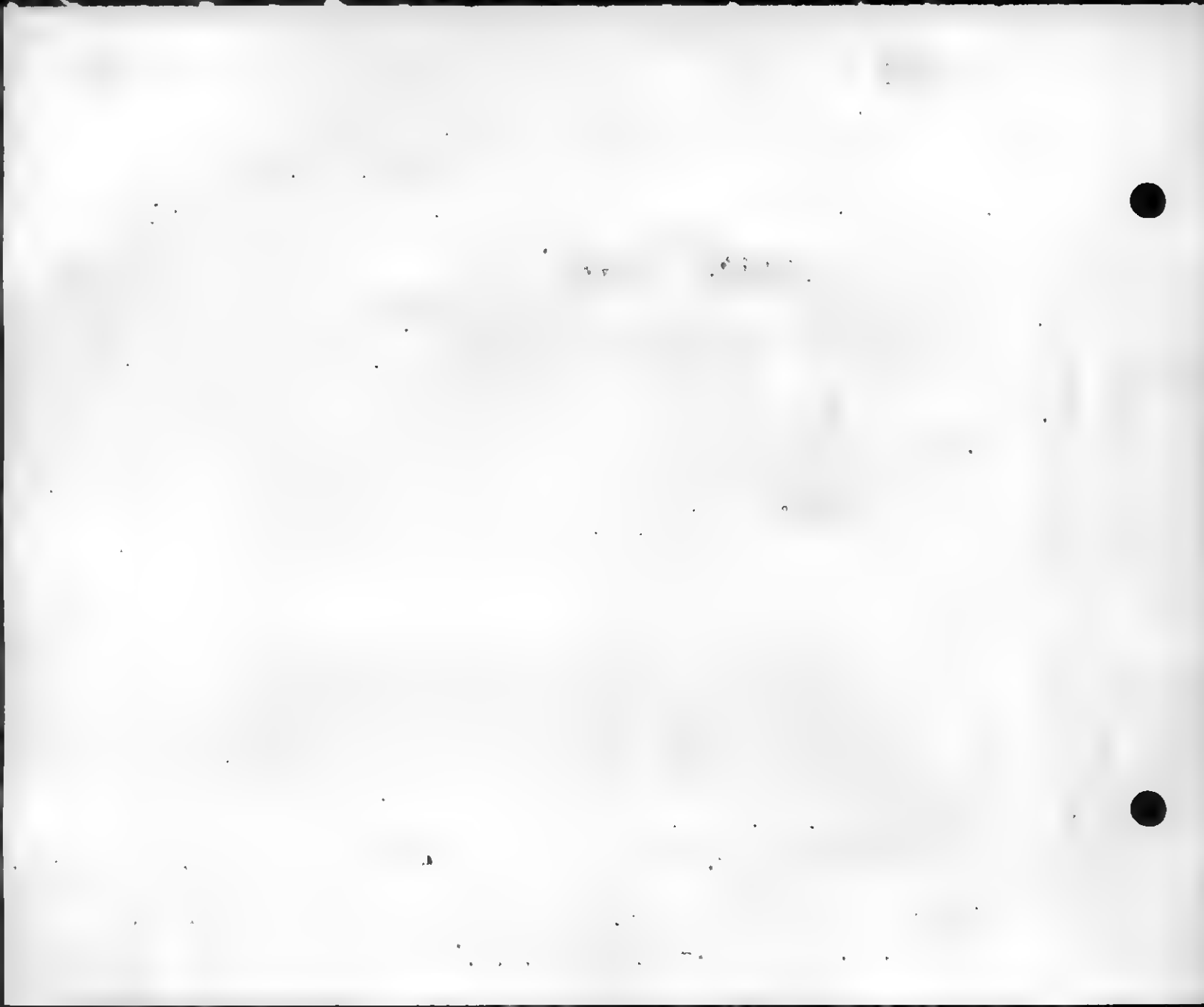


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**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**  
**CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN ID <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>706 New Jersey Avenue N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>Ellen P. Cokas</u> <b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>10</u> Year <u>1966</u>		<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>8. DATE OF BIRTH</b> <u>2-17-19</u> <b>9. AGE</b> (In years last birthday) <u>71</u> yrs. <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Greece</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>American</u>	
<b>13. FATHER'S NAME</b> <u>George Panopoulos</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Zuras</u>		<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> <b>16. SOCIAL SECURITY NO.</b> <u>No</u> <b>17. INFORMANT</b> <u>Records - Washington San. Hosp. &amp; Add.</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Intestinal obstruction</u> <u>1538</u> DUE TO (b) <u>Ca of Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Diabetes Mellitus</u>		<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>1 week</u>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) _____ <b>20c. TIME OF INJURY</b> Month, Day, Year _____ Hour a.m. _____ p.m. <u>1pm</u> 19 <u>66</u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) _____ <b>20f. (City or town) (County) (State)</b> _____		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 6</u> , 19 <u>66</u> , to <u>Feb 10</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 2-10</u> 19 <u>66</u> , and that death occurred at <u>1pm</u> from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>Raymond O. West</u> <b>22b. DATE SIGNED</b> <u>2-10-66</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Raymond O. West</u> <b>22d. ADDRESS</b> <u>7600 Carroll Avenue, Takoma Park, Maryland</u>	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>2/14/66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Glenwood Cemetery</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Washington, D.C.</u>		<b>24. FUNERAL DIRECTOR</b> <u>The S. H. Hines Co.</u> <b>25a. RECEIVED BY REGISTRAR</b> <u>FEB 11 1966</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

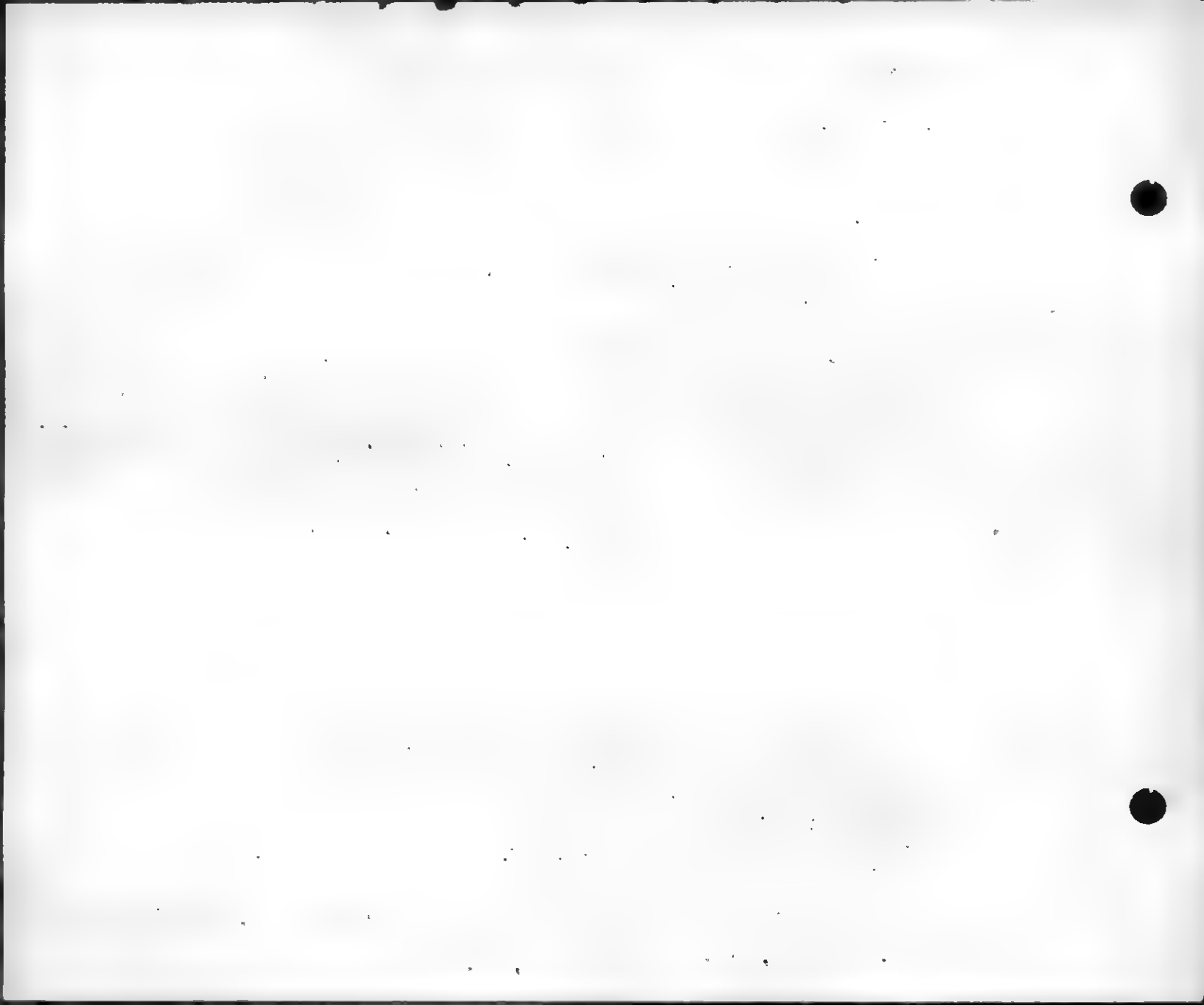
## CERTIFICATE OF DEATH

02435

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>14 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sen. Cdr. Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8712 Catesville Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>Carrie Ruth Coleman</u>		4. DATE OF DEATH <u>Feb 25 1966</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-27-15</u>		9. AGE (In years last birthday) <u>50 yrs.</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary American Instrument Co.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Barker</u>				14. MOTHER'S MAIDEN NAME <u>Lee Mc Neil</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>Yes</u>				17. INFORMANT <u>Harry Barker</u> Address <u>407 Hilltop Drive S.S., Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMATOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ADENOCARCINOMA OF BREAST</u> DUE TO (c) <u>HOS</u>												INTERVAL BETWEEN ONSET AND DEATH <u>HOS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>FEB. 11, 1966</u> to <u>FEB 25, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 25 1966</u> , and that death occurred at <u>9:55 P</u> M, from the causes and on the date stated above.																			
22a. SIGNATURE <u>Albert H. Grollman</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>2/26/66</u>				22c. PHYSICIAN'S NAME (TYPE) <u>ALBERT H. GROLLMAN MD 1106 SPRING ST. SILVER SPRING MD</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>3-1-66</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Deer Creek Harmony Presbyterian Ch.</u>				23d. LOCATION (City, town or county) (State) <u>Darlington Md.</u>							
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

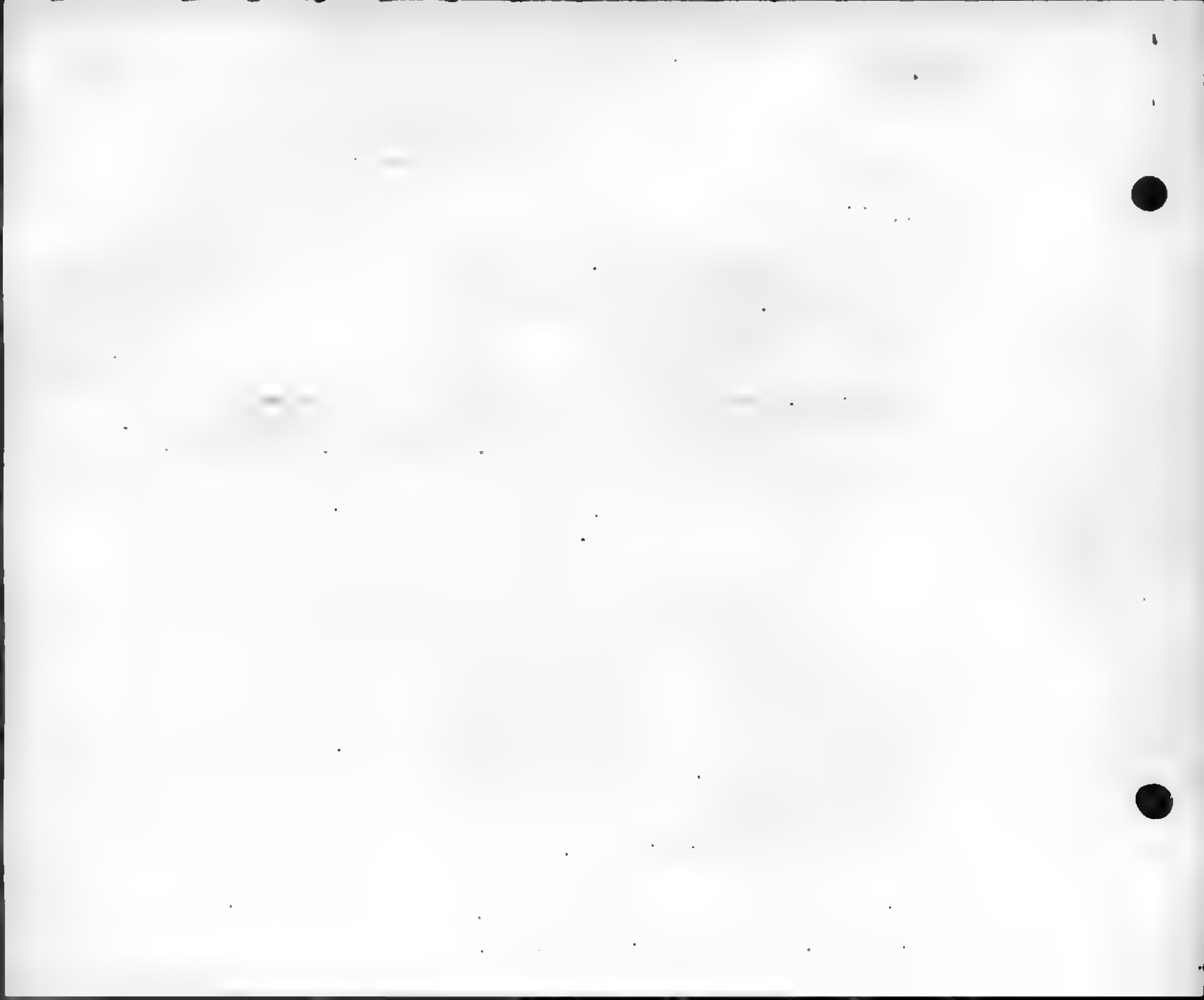
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please rejoin carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
02479		02436	
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>5017 Euclid Street</b>		d. STREET ADDRESS <b>5017 Euclid Street</b>	
3. NAME OF DECEASED (Type or print) First <b>Stuart</b> Middle <b>H.</b> Last <b>Conover</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/5/1912</b>
9. AGE (in years last birthday) <b>53</b>		IF UNDER 1 YEAR Months <b>9</b> Days <b>18</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sales</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Lemuel C. Conover</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Darnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Mrs. Dorothy B. Conover Garrett Pk, Md</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. INTERVAL BETWEEN ONSET AND DEATH <b>5 Mos.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>58</b> , to <b>Feb 23</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Feb 21</b> , 19 <b>66</b> , and that death occurred at <b>3:45</b> AM, from the causes and on the date stated above.			
22a. SIGNATURE <b>George Sharpe</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>George Sharpe, M.D.</b>		22d. ADDRESS <b>10511 Summit Ave., Kensington, Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2/25/66</b>		23b. DATE THEREOF <b>2/25/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Pleasantville Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Pleasantville, N.J.</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Bethesda, Md.</b>		25a. REC'D BY REGISTRAR <b>FEB 25 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>John L. Judge</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

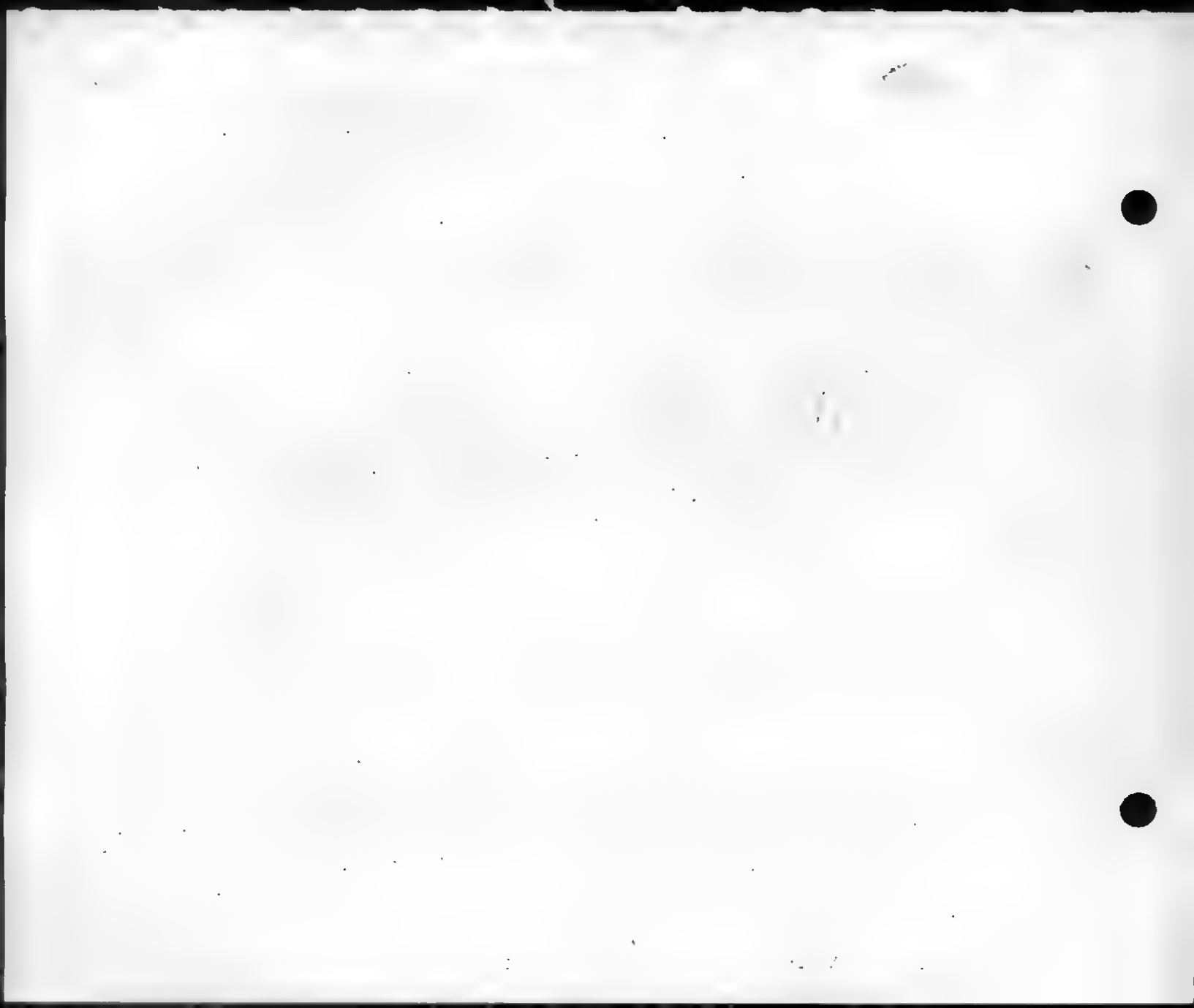
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02480

02437

1. PLACE OF DEATH a. COUNTY Montgomery County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE 1404 Merrimac Dr. Md.		b. COUNTY District	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Takoma Park		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Langley Park, Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Sanitarium Hospital		d. STREET ADDRESS 1404 Merrimac Dr. Montgomery County		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Susanna K. CORADETTI		4. DATE OF DEATH Feb 27 1966		5. SEX F.	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-1975	
9. AGE (in years last birthday) 40 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY —	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? American		13. FATHER'S NAME JOHN KARNNEY	
14. MOTHER'S MAIDEN NAME ANN PADDEN		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-44-499	
17. INFORMANT FRANK CORADETTI		Address 5934 27th Ave NW SE		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, right + LIX DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 2/23, 1966, to 2/27, 1966, that (I) (we) last saw the deceased alive on 2/27, 1966, and that death occurred at 4:34 A.M. from the causes and on the date stated above.					
22a. SIGNATURE William F. Simpson		22b. DATE SIGNED 2/27/66		22c. PHYSICIAN'S NAME (Type) William F. Simpson	
22d. ADDRESS 6216 N.H. Ave NE - DC.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Mar 2, 1966		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven	
23d. LOCATION (City, town or county) (State) Wheaton, Md.					
24. FUNERAL DIRECTOR W.W. Taltavull		25a. REC'D BY REGISTRAR 3603-18 NEW DC		25b. REGISTRAR'S SIGNATURE JULY 1966 Judge	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

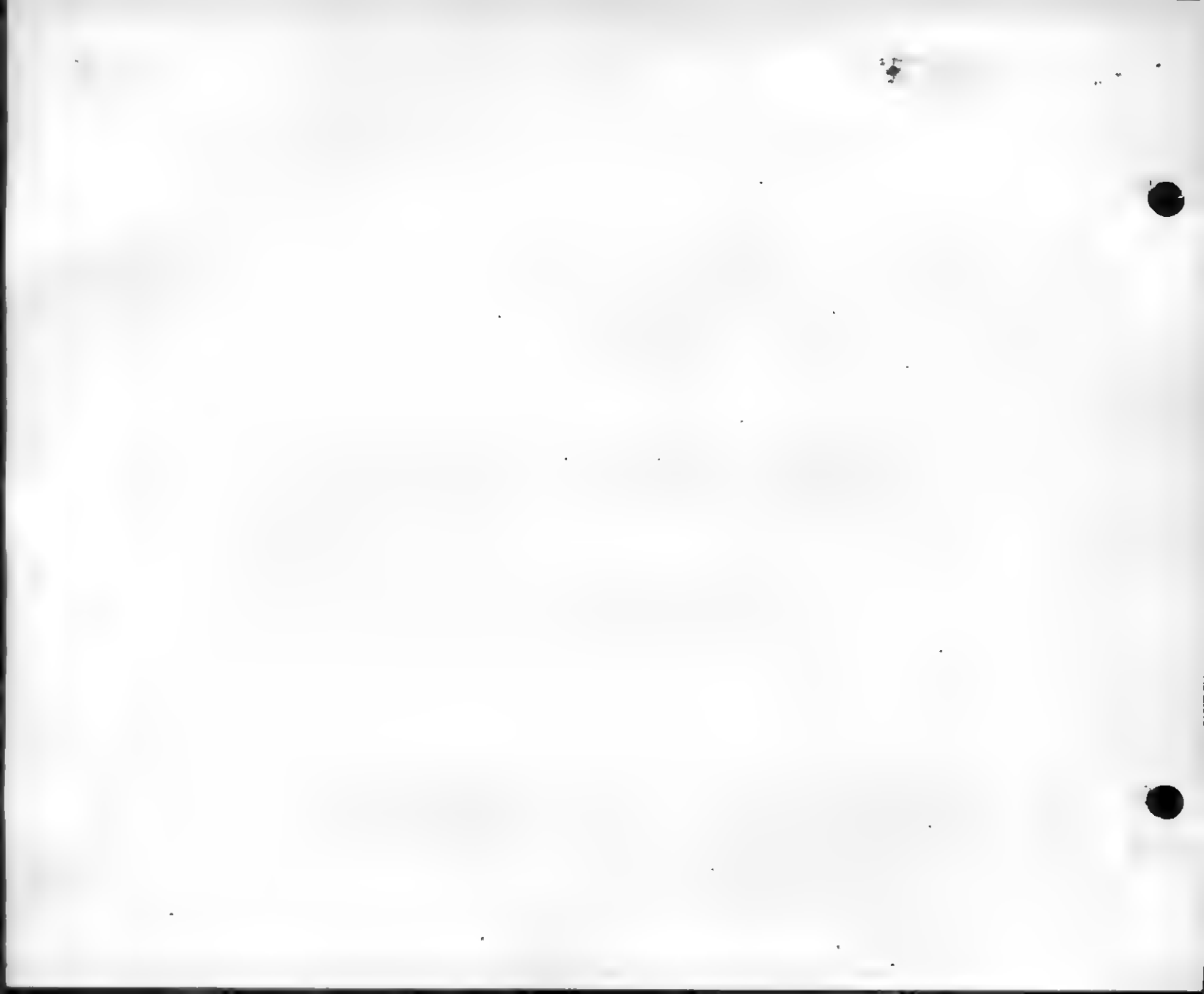
02481

02438

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry Chase</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				d. STREET ADDRESS <u>4700 Bradley Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ethel</u> Middle <u>J</u> Last <u>Crainford</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>11/3/90</u>	
9. AGE (In years last birthday) <u>75</u> yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George J. Nash</u>				14. MOTHER'S MAIDEN NAME <u>Ella Caggins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO <u>578-30-0240</u>		17. INFORMANT <u>Ethel L. Butler</u> Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchogenic CARCINOMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Due to</u> (c) <u>Due to</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 1/2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE HEART FAILURE, ART. C-VASCULAR DISEASE</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Nov 1</u> , 19 <u>65</u> , to <u>2-9</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>2-9</u> 19 <u>66</u> , and that death occurred at <u>9:40 P.M.</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Edward W. Youngblood</u> M.D.				22b. DATE SIGNED <u>2-10-66</u>		22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. YOUNGBLOOD</u>	
22d. ADDRESS <u>WASHINGTON CLINIC, WASHINGTON 15, D.C.</u>				23a. BURIAL (CREMATION, REMOVAL) <u>Burial</u>			
23b. DATE THEREOF <u>2/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glenwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>			
24. FUNERAL DIRECTOR <u>Robert A. Punchrey</u> ADDRESS <u>Bethesda, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02482

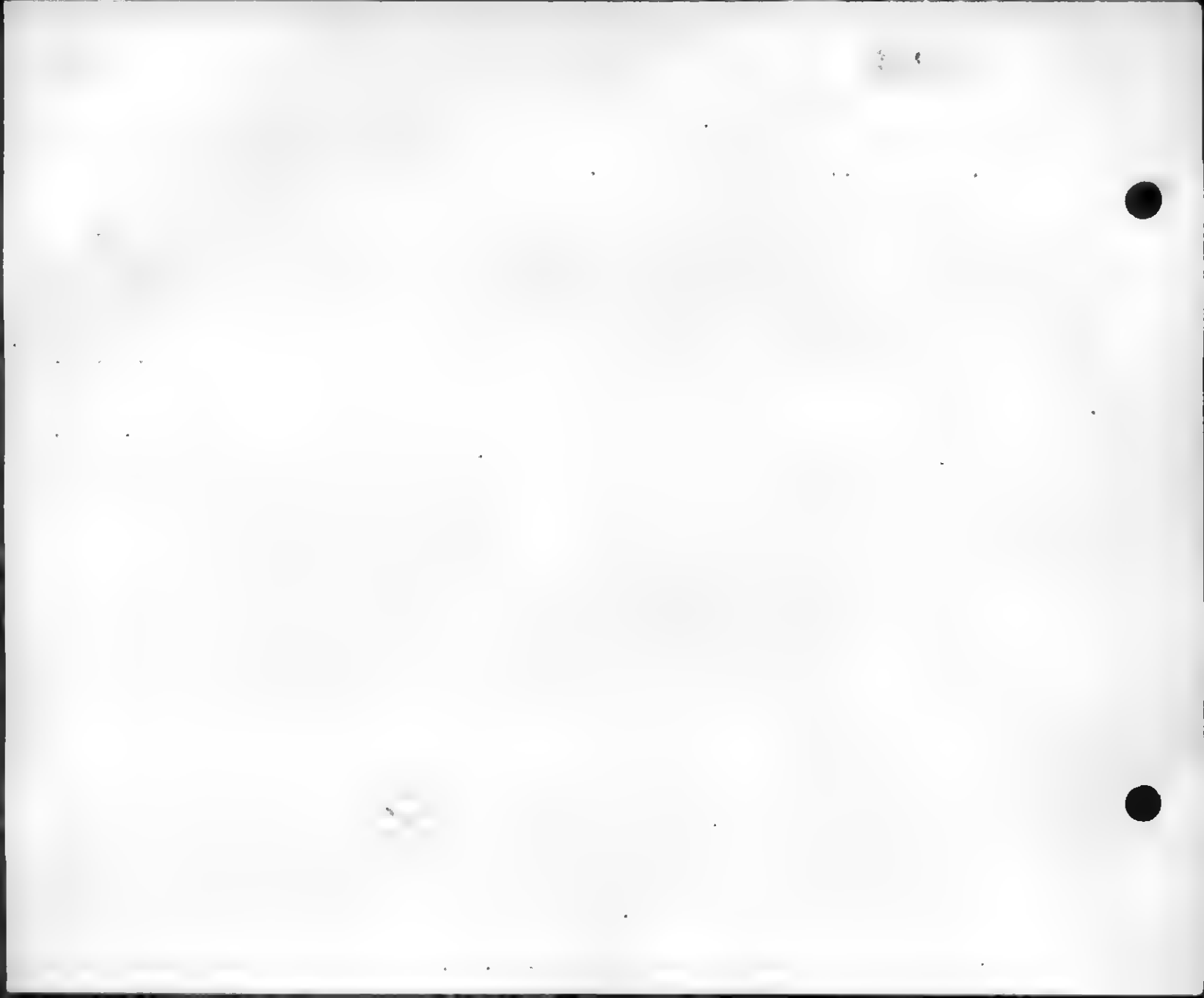
## CERTIFICATE OF DEATH

02439

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b> <b>Holy Cross Hosp.</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spr., Montgomery Coun.</b> c. LENGTH OF STAY IN 1b <b>Maryland</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Silver Spring</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Maryland</b> d. STREET ADDRESS <b>8201 16th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry</b> First <b>Cutler</b> Middle <b>Cutler</b> Last 5. SEX <b>M</b> 6. COLOR OR RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <b>Feb 25</b> Month <b>19</b> Day <b>66</b> Year 8. DATE OF BIRTH <b>6/10/89</b> 9. AGE (in years last birthday) <b>76</b> yrs. 10. FINDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. 11. FINDER 24 HRS. Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Liquor Dealer</b> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <b>Poland</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Abraham Cutler</b> 14. MOTHER'S MAIDEN NAME <b>Sarah ---</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>(If yes give war or dates of service)</b> 16. SOCIAL SECURITY NO. <b>577-48-1695</b> 17. INFORMANT <b>Mrs. Jean Binder</b> Address <b>S. S., Md. 8503 Leonard Dr.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular fibrillation</b> 1201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>Acute Coronary Occlusion Spots</b> DUE TO (b) <b>Coronary Arteriosclerosis</b> DUE TO (c) <b>16 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>March 19, 1966</b> to <b>Feb 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 25, 1966</b> , and that death occurred at <b>12 AM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>Benjamin Manchester</b> 22c. PHYSICIAN'S NAME (Type) <b>BENJAMIN MANCHESTER</b>		22b. DATE SIGNED <b>2-25-66</b> 22d. ADDRESS <b>3200-16 St N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 23b. DATE THEREOF <b>2/27/66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b> 23d. LOCATION (City, town or county) (State) <b>Hyattsville, Maryland</b>		24. FUNERAL DIRECTOR <b>B. DANZANSKY &amp; SONS</b> ADDRESS <b>Washington, D. C. 3501 14th St. N. W.</b> 25a. REC'D BY REGISTRAR <b>Feb 28 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. H. Jones</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

to  
M  
Cleared by Dr Reep/Blaygas  
BP Coronary. Autopsy will be performed.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

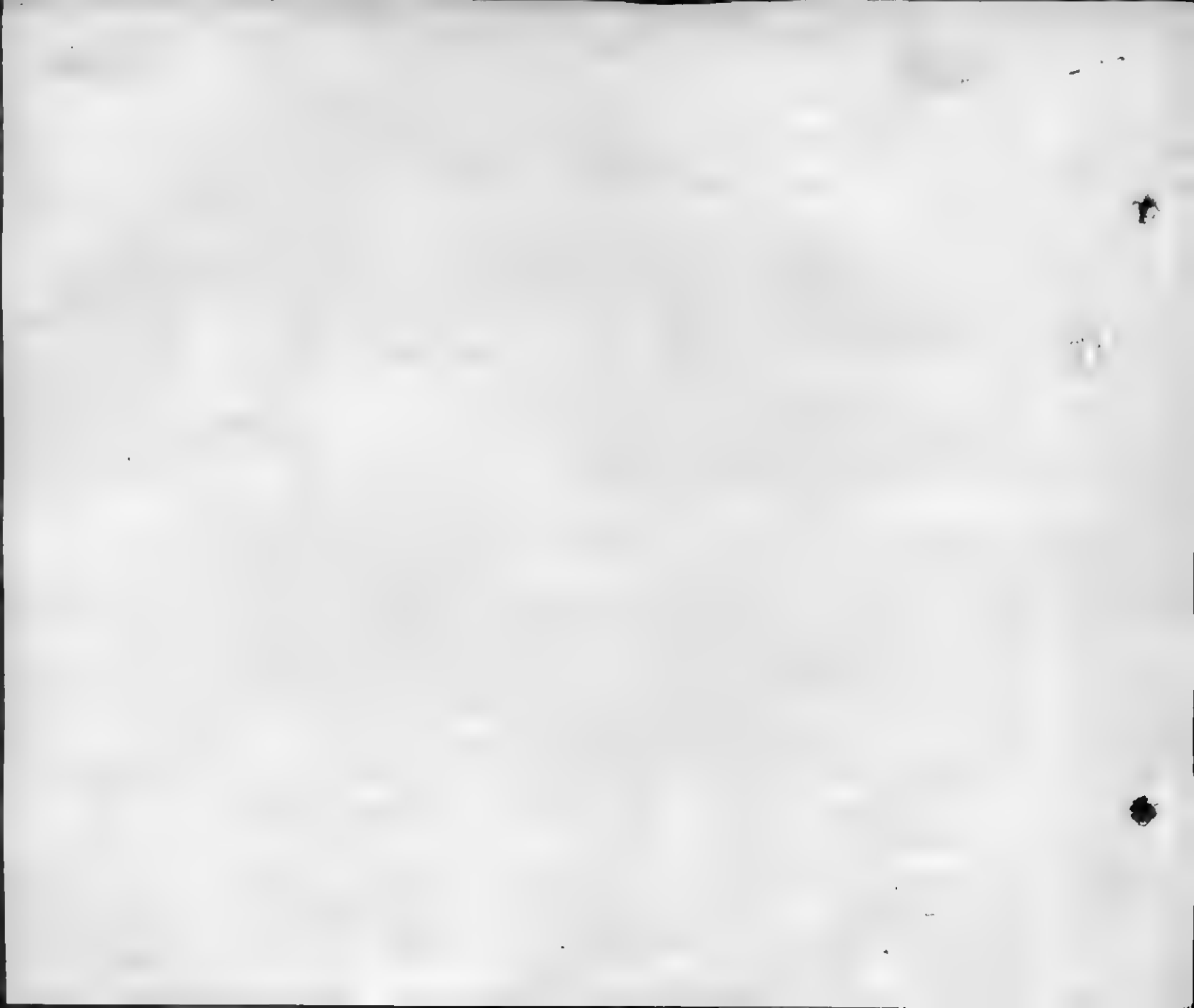
02483

02440

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wheaton Nursing Home</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>3128 Patterson Pl. N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARGARET</u> First Middle Last <u>H</u> <u>DEATLEY</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>14</u> Year <u>1966</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>July 12 1890</u>
<b>9. AGE</b> (in years last birthday) <u>75</u> yrs.	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>housewife</u>	<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Kentucky</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>
<b>13. FATHER'S NAME</b> <u>Unknown</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>Unknown</u>	
<b>17. INFORMANT</b> <u>Lawrence DeAtley</u>		<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) <u>arterio-sclerotic heart disease</u> DUE TO (c)	
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<b>20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner) <input type="checkbox"/>	
<b>21. I certify that (I) (this hospital) attended the deceased from...</b> <u>2-7</u> <b>1966</b> , to <u>2-14</u> <b>1966</b> , that (I) (we) last saw the deceased alive on <u>2-14</u> <b>1966</b> , and that death occurred at <u>1:54 AM</u> , from the causes and on the date stated above.		<b>22a. SIGNATURE</b> <u>E H Markman</u>	
<b>22b. DATE</b> <u>2-14-66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>E H Markman</u>	
<b>22d. ADDRESS</b> <u>3208 - 17th Ave NW, DC 20010</u>		<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>	
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial-Transit 2/17/66</u>		<b>23b. DATE THEREOF</b> <u>2/17/66</u>	
<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Maysville Cemetery</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Maysville, Kentucky</u>	
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Robert A. Pumphrey Bethesda, Md.</u>		<b>25. REC'D BY REGISTRAR</b> <u>FEB 16 1966</u>	
<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. J. J. J.</u>		<b>25c. REGISTRAR'S SIGNATURE</b> <u>J. J. J. J.</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the certificate to the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

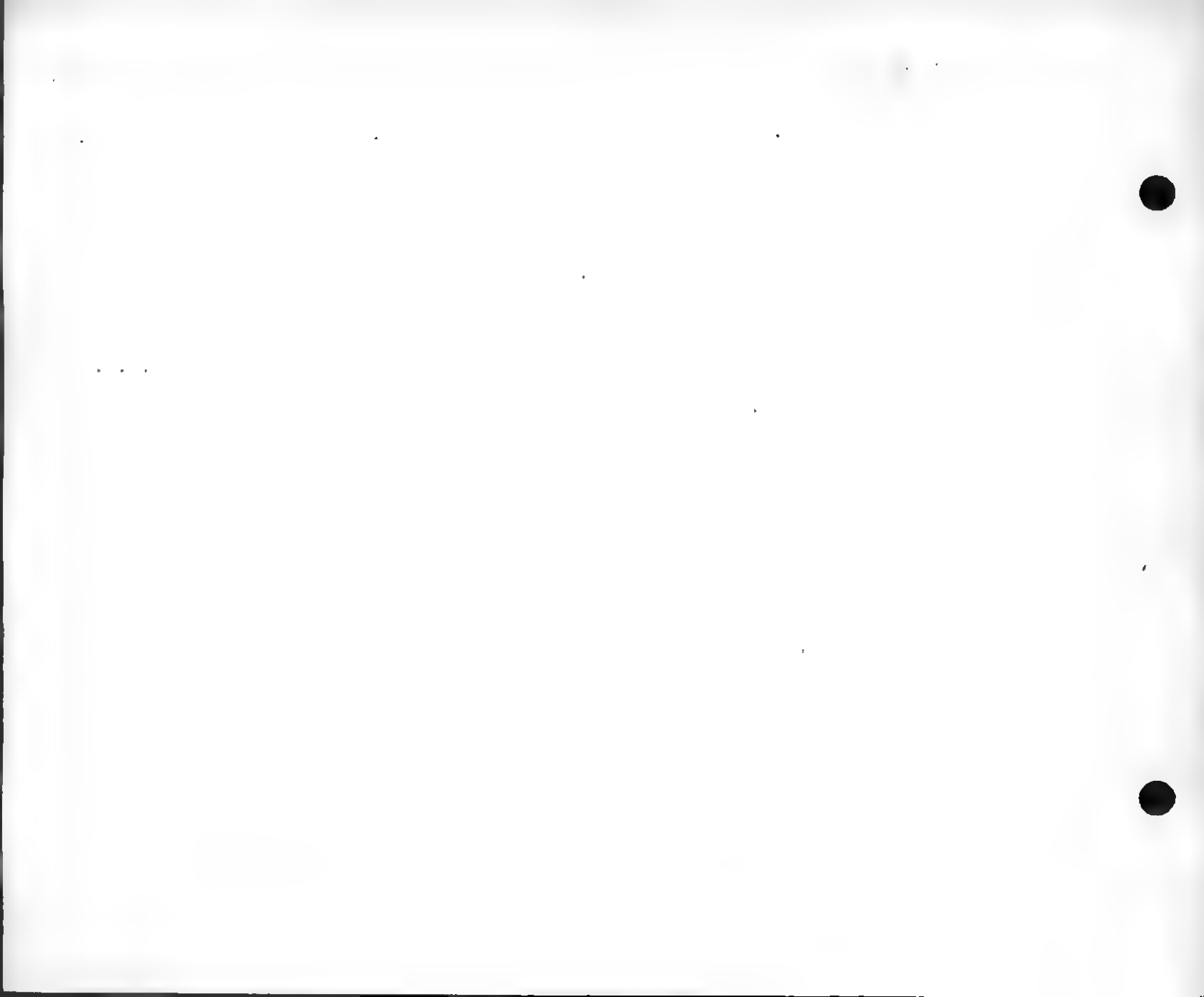
VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02484

02441

1 PLACE OF DEATH a COUNTY <u>Mont. Co.</u> MARYLAND				2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>MD.</u> b COUNTY <u>Mont. Co.</u>			
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>		c LENGTH OF STAY IN IL <u>24 hr.</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>			
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>223 E. Montgomery Ave.</u>				d STREET ADDRESS <u>9 North Adams St.</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Raymond</u> Middle <u>S.</u> Last <u>Dodson</u>				4 DATE OF DEATH Month <u>Feb.</u> Day <u>22</u> Year <u>1966</u>			
5 SEX <u>Male</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/19</u>		9 AGE (In years last birthday) <u>46</u> yrs	10 IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS Hours <u>  </u> Min <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Surveyor</u>		10b KIND OF BUSINESS OR INDUSTRY <u>  </u>		11 BIRTHPLACE (State or foreign country) <u>Virginia</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>George W. Dodson</u>				14 MOTHER'S MAIDEN NAME <u>Sarah Alice Williams</u>			
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16 SOCIAL SECURITY NO <u>230-14-5087</u>		17 INFORMANT Address <u>Brother Wm. A. Dodson</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>  </u> DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis, liver, severe</u>						19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c TIME OF INJURY Month Day Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/23/66</u>			
				Address (Street, city, town, or county)			
23a BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		23b DATE THEREOF <u>2-25-66</u>		23c NAME OF CEMETERY OR CREMATORY <u>Fairfields Bap. C. Cem.</u>		23d LOCATION (City or Town) (County) (State) <u>Burgess, North'do, Md.</u>	
24 FUNERAL DIRECTOR <u>James Ash</u>				25a REC'D BY REGISTRAR <u>Feb 25 1966</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

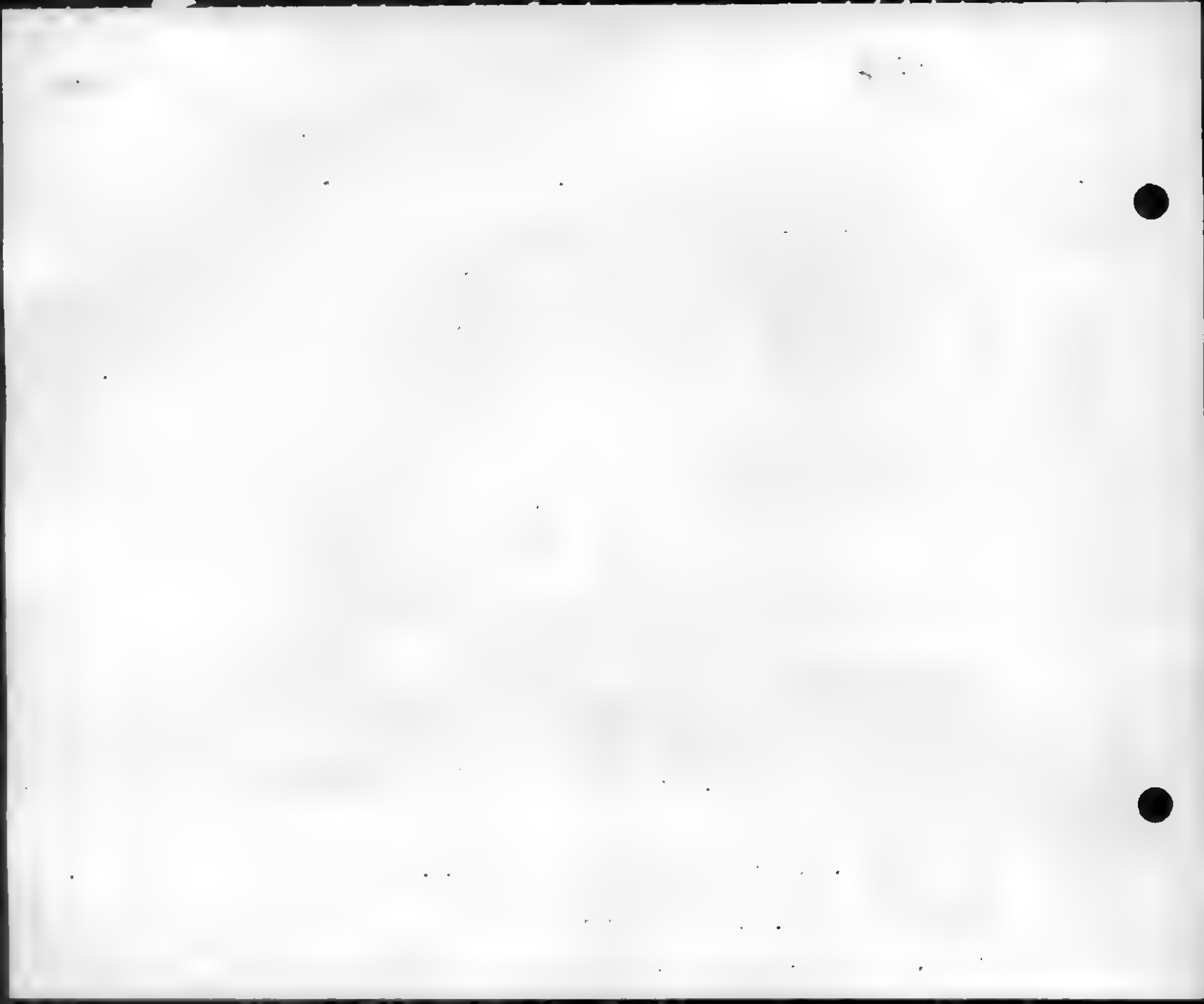
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02485

CERTIFICATE OF DEATH

02443

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admss. on) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RJRAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY in 1b <b>17 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McKnights Town</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS		e. IS RES DENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Dorothy</b> Middle <b>Hickok</b> Last <b>Drum</b>				4. DATE OF DEATH Month <b>February</b> Day <b>5</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 27, 1892</b>	9. AGE (In years last birthday) <b>73</b> yrs	F UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hillard Hickok</b>				14. MOTHER'S MAIDEN NAME <b>Mary Cronestier</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Mr. Charles H. Drum</b> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Generalized carcinoma, site unknown--</b> <b>163 x</b> DUE TO <b>Suspected lung.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>at</del> (this hospital) attended the deceased from <b>Jan. 19, 1966</b> , to <b>Feb. 5, 1966</b> , that <del>he</del> (we) last saw the deceased alive on <b>Feb. 5, 19 66</b> , and that death occurred at <b>4:45 AM</b> , from causes and on the date stated above							
22a. SIGNATURE <b>J. B. BERRY</b>				M.D. ATTENDING PHYS <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>Feb. 5, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>J. B. BERRY LTJMC USN</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, REMOVA, (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 7, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Gettysburg, Pennsylvania</b>	
24. FUNERAL DIRECTOR <b>Bender, Gettysburg, Pennsylvania</b>				25a. REC'D BY REGISTRAR <b>DATE FEB 9 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	



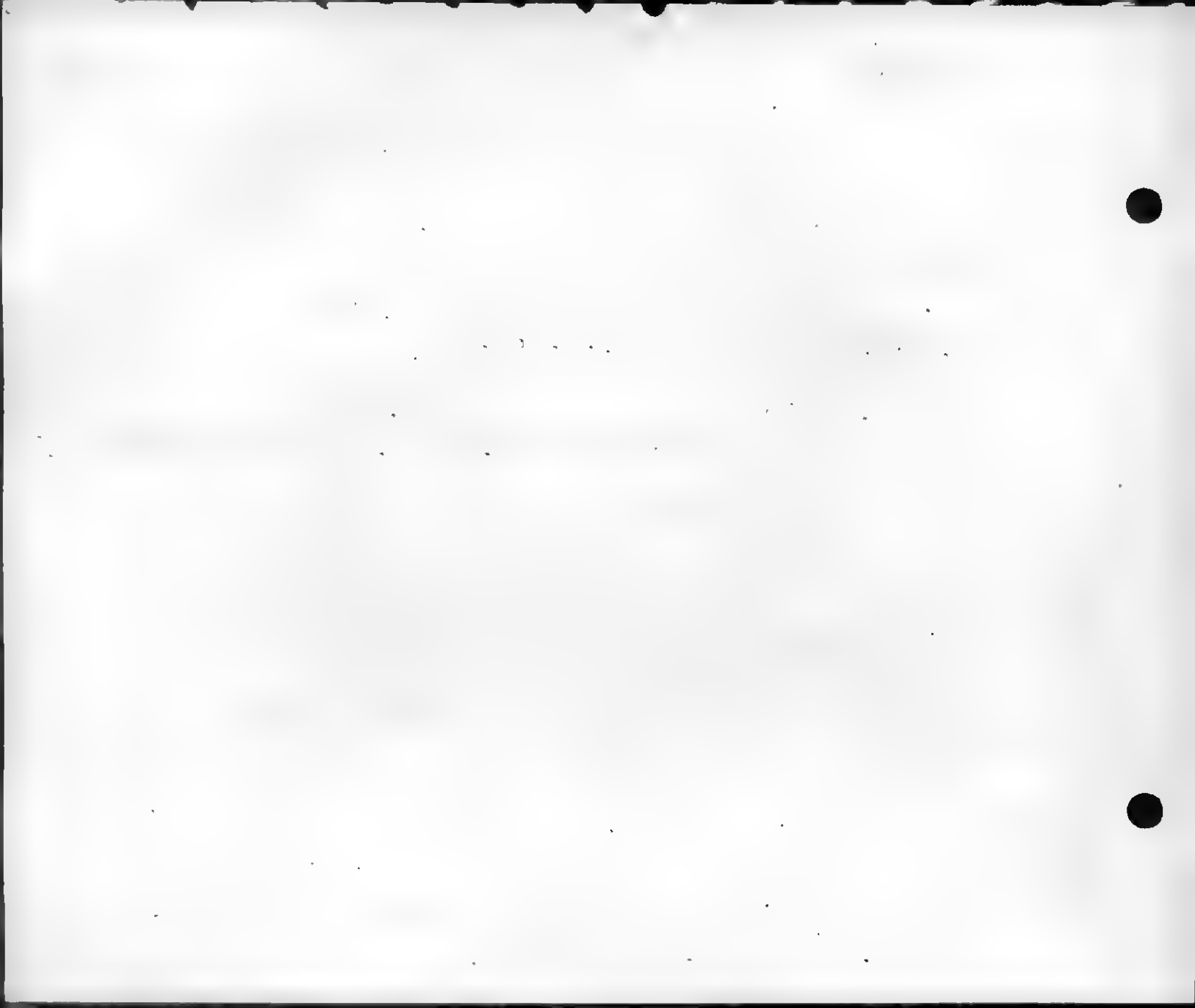
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02486

0244

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		c. LENGTH OF STAY IN ID <u>5 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>935 BODIFANT</u>			
3. NAME OF DECEASED (Type or print) First <u>VIVIAN</u> Middle <u>MORRISON</u> Last <u>DUNCAN</u>				4. DATE OF DEATH Month <u>2</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jun 26 1898</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>19</u>	IF UNDER 24 HRS. Hours <u>19</u> Min. <u>00</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William B. Morrison</u>				14. MOTHER'S MAIDEN NAME <u>Ella E. Hume</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>578-32-1478</u>		17. INFORMANT <u>Mrs. Henry H. Tetrault</u> <u>10278 Meedith Ave. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute renal failure, cause unknown</u> <u>3X</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>2/14</u> , 19 <u>66</u> , to <u>2/19</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/19</u> , 19 <u>66</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard H. Pollen</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>				22d. ADDRESS <u>1051 SUMMIT AVE KENNESAW, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			



DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02487

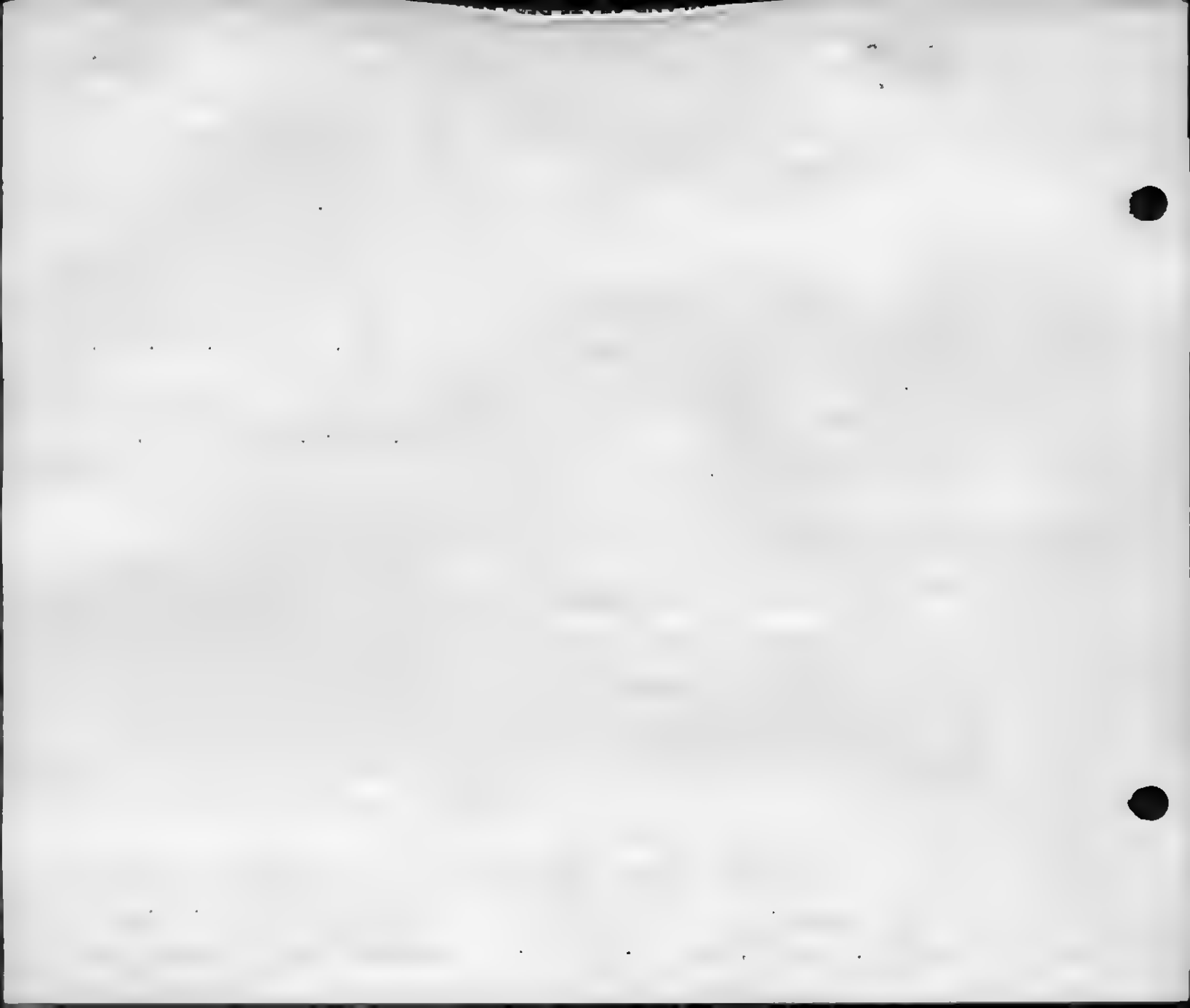
CERTIFICATE OF DEATH

Items 8 & 9, Film G-34 3/7/66 cac

02445

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. It is please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Gaithersburg</u>	
c. LENGTH OF STAY IN TB <u>61 yrs</u>		d. STREET ADDRESS <u>10 Oak Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Merton</u> Middle <u>Fairall</u> Last <u>Duvall</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>21st</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 26th 1904</u>
9. AGE (in years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>10</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>III</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Gaithersburg. Montg. Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>Md. U.S.A.</u>	
13. FATHER'S NAME <u>Calvin Scott Duvall</u>		14. MOTHER'S MAIDEN NAME <u>Sarah L. Fairall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Pearl W. Duvall. Gaithersburg. Md.</u>	
17. INFORMANT <u>Pearl W. Duvall. Gaithersburg. Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Myocardial infarction</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>?</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2-19-1966</u> to <u>2-21-1966</u> , that (I) (we) last saw the deceased alive on <u>2-19-1966</u> , and that death occurred at <u>9:40 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>J. J. Bruschant</u>		22b. DATE SIGNED <u>2-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. J. Bruschant</u>		22d. ADDRESS <u>Gaithersburg, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Forest Oak</u>	23d. LOCATION (City, town or county) (State) <u>Gaithersburg, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Ernest C. Gartner, Gaithersburg, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 25 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

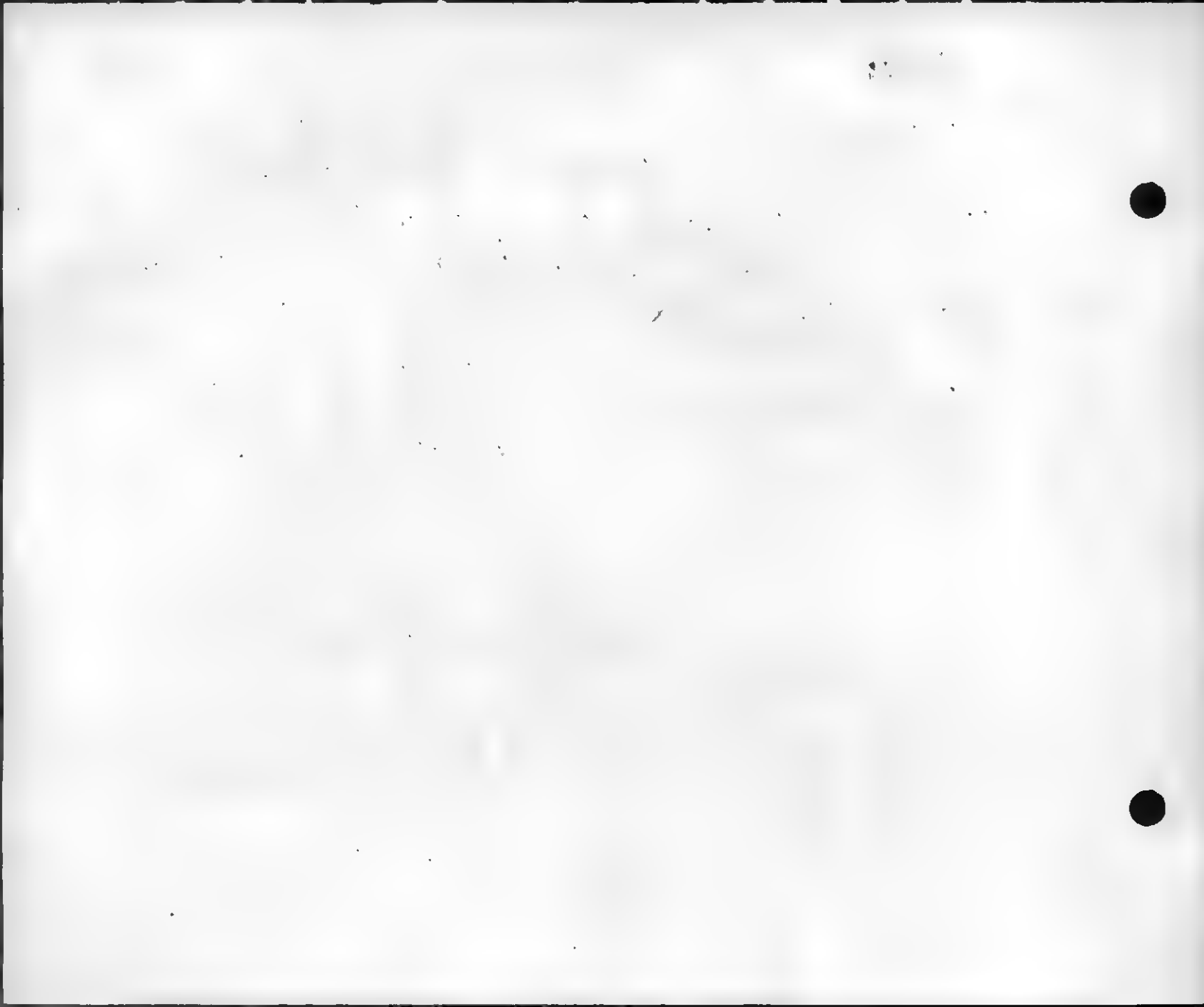




1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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M

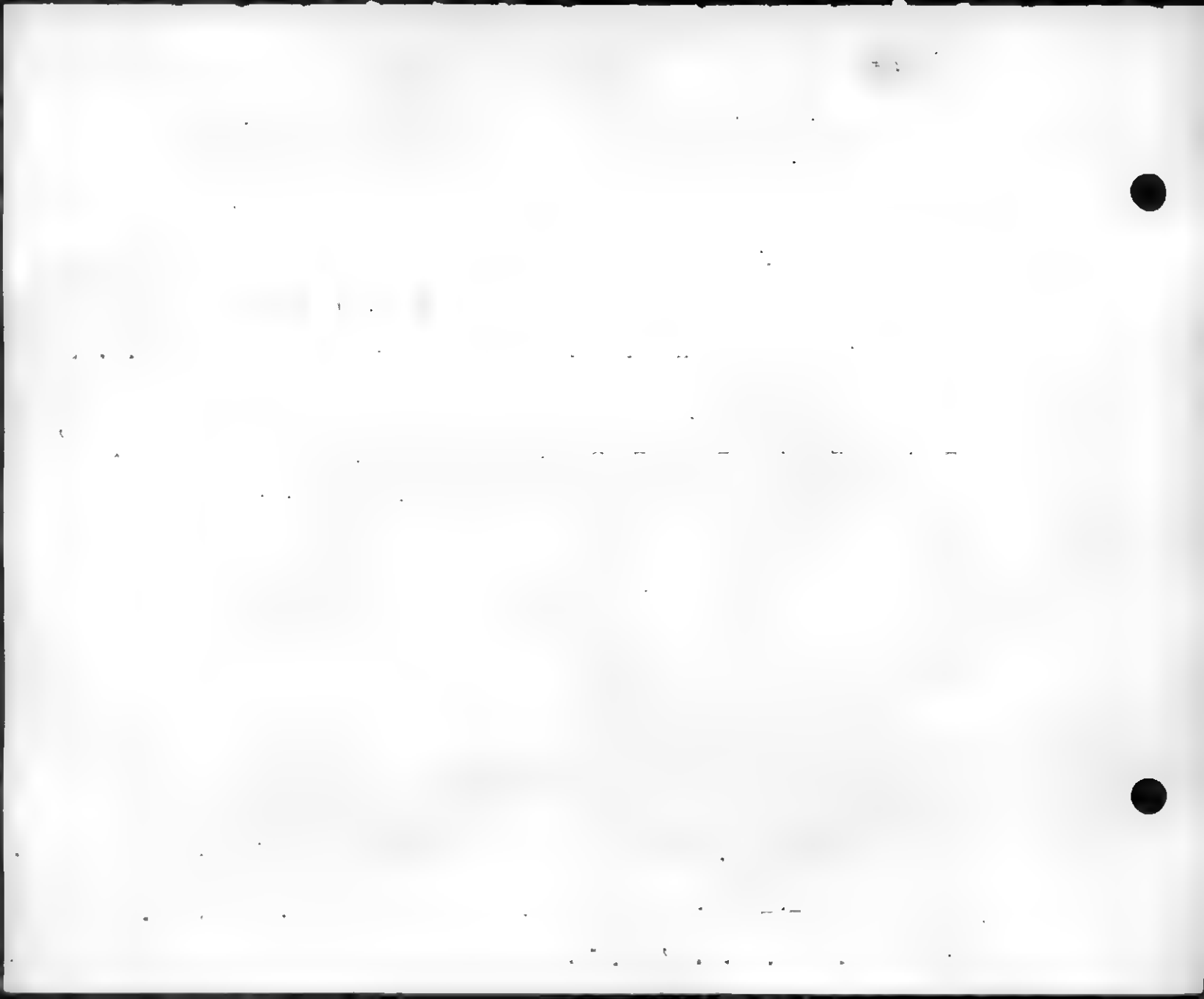
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02488						02446					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE			b. COUNTY		
Montgomery			Takoma Park			Maryland			Hyattsville		
c. LENGTH OF STAY IN 1b			d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
12 hrs 35 min			Washington Sanitarium + Hospital			Hyattsville			4406 Tuckerman		
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH		e. IS RESIDENCE ON A FARM?			
First Middle Last ERNEST ELIGENE EMERSON						Month Day Year 2 - 27 19 66		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. CITIZEN OF WHAT COUNTRY?	
Male		white				6-6-78		87 yrs.		USA.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
						Maryland			USA.		
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Ernest Emerson						Georanna Grimes					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
none						Hospital Records					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, Bilateral Fulminating										2 days	
+93X DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Congestive Heart Failure - Atherosclerosis											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)										20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2 - 1955, to 2-26, 1966, that (I) (we) last saw the deceased alive on 2-26 1966, and that death occurred at 5 AM, from the causes and on the date stated above.										22b. DATE SIGNED	
22a. SIGNATURE Robert B. Tney										22c. PHYSICIAN'S NAME (Type) Robert B. Tney	
22d. ADDRESS 7105 Riggs Rd Hyattsville, Md										22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22f. DATE SIGNED 2-27-66											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (city, town or county) (State)			
Burial				March 2, 1966		Rock Creek Cemetery		Washington D. C.			
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
F. Jackson - Hyattsville, Md						MAR 3 1966		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
<div style="display: flex; justify-content: space-between;"> <span>02489</span> <span>Item #1d Film #0373 2/15/66</span> <span>02448</span> </div>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>						c. LENGTH OF STAY IN 1b <u>Bethesda</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>5602 Madison St.</u>						d. STREET ADDRESS <u>5602 Madison Street</u>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>ALICE M. EVANS</u>						4. DATE OF DEATH <u>Feb 2 1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov-19-1874</u>		9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>- - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Missouri</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Highley</u>						14. MOTHER'S MAIDEN NAME <u>Anne Westover</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>- - -</u>				16. SOCIAL SECURITY NO. <u>218-54-5329</u>		17. INFORMANT <u>Helen Evans, 5602 Madison St.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Hypertensive Cardio Vascular Disease</u> DUE TO (c) <u>Arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senile Emphysema</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1959</u> to <u>Feb 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 1 1966</u> , and that death occurred at <u>8:20</u> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>James E. Nolan</u> M.D.						22b. DATE SIGNED <u>Feb 3-66</u>					
22c. PHYSICIAN'S NAME (Type) <u>James E. Nolan</u>						22d. ADDRESS <u>Washington Clinic, Western Ave.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				23b. DATE THEREOF <u>2-5-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Farmington Mo.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. DC.</u>											
25a. REC'D BY REGISTRAR <u>FEB 89 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>											



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

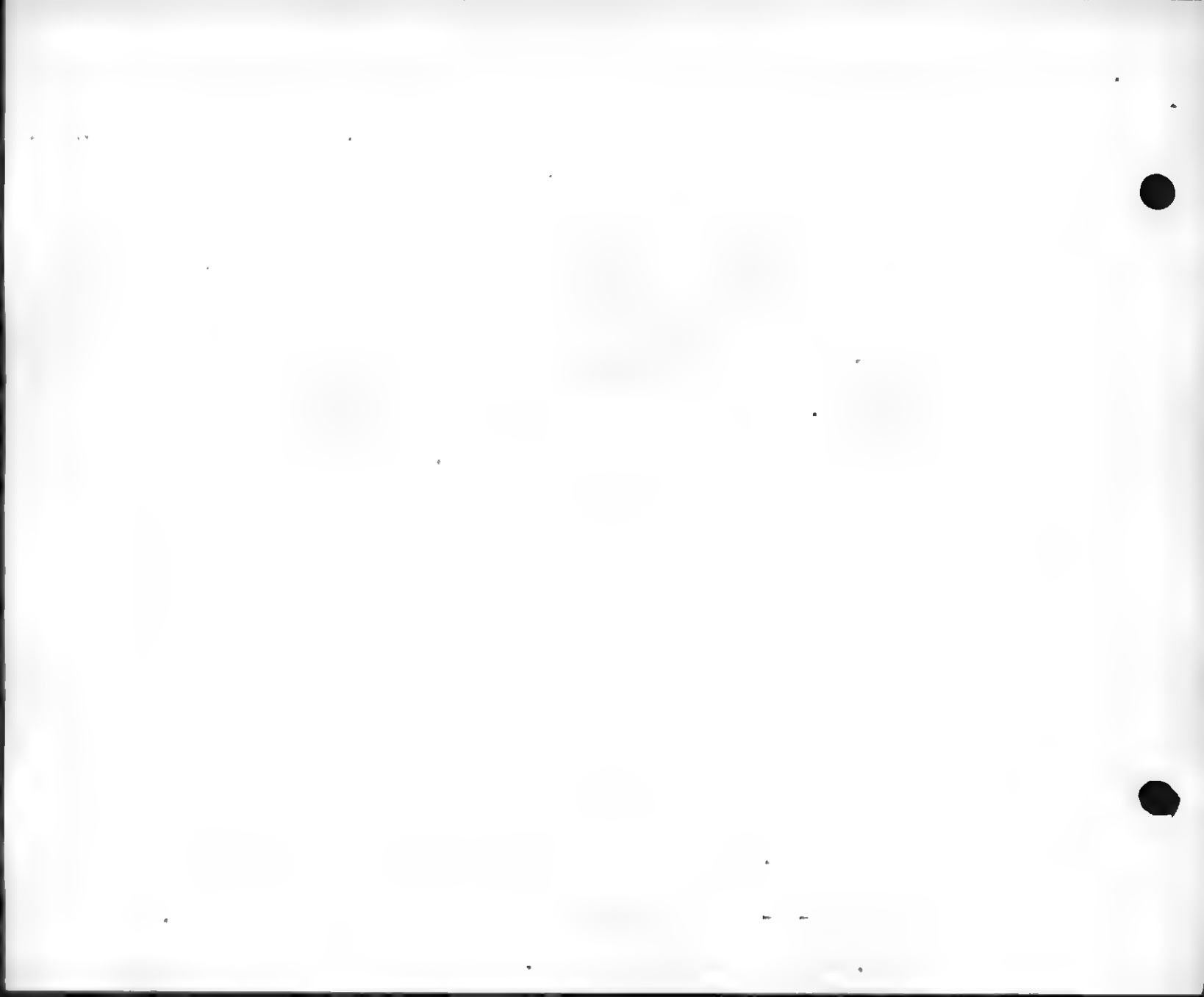
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02490

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02449

1 PLACE OF DEATH a COUNTY <b>Mont. CO.</b>		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <b>Md.</b> b COUNTY <b>Frederick</b> <b>Mont. Co.</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c LENGTH OF STAY IN 1b <b>D.C.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d STREET ADDRESS <b>None</b>	
3 NAME OF DECEASED (Type or print) First Middle Last <b>Charles McClelland Evans</b>		4 DATE OF DEATH Month Day Year <b>Feb. 11 19 66</b>	
5 SEX <b>Male</b>	6 COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>8/23/03</b>
9 AGE (In years, months, and days) <b>62</b>		10 IF UNDER 1 YEAR Months Days <b>11 19</b>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b KIND OF BUSINESS OR INDUSTRY <b>Painting</b>	
11 BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Charles R. Evans</b>		14 MOTHER'S MAIDEN NAME <b>Vella Woodring</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes 1920</b>		16 SOC. A. SECURITY NO <b>Unknown</b>	
17 INFORMANT <b>Mrs. Charles Evans</b>		Address <b>Same as 2</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Fracture of Cervical Spine &amp; chord compression</b> DUE TO (b) <b>Auto. Accident</b> DUE TO (c) <b>Auto. Accident</b> Conditions, (any which gave rise to immediate cause (a), stating the underlying cause last)			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Coronary Intention</b>			
20a EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING? CAUSE OF DEATH <input checked="" type="checkbox"/>		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Collision with Auto. Head-on - when drove his car over yellow</b>	
20c TIME OF INJURY Month, Day Year <b>3:35 p.m. Feb 11 19 66</b>		20d INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Highway 108</b>		20f (City or town) (County) (State) <b>R. Damascus Mont. Md.</b>	
21 I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John G. Ball</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2/12/66</b>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>2-15-66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Liberty Baptist</b>		23d LOCATION (City or town) (County) (State) <b>Lisbon Md.</b>	
24 FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a REC'D BY REGISTRAR <b>FEB 16 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Laytonsville, Md.</b>		25c REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

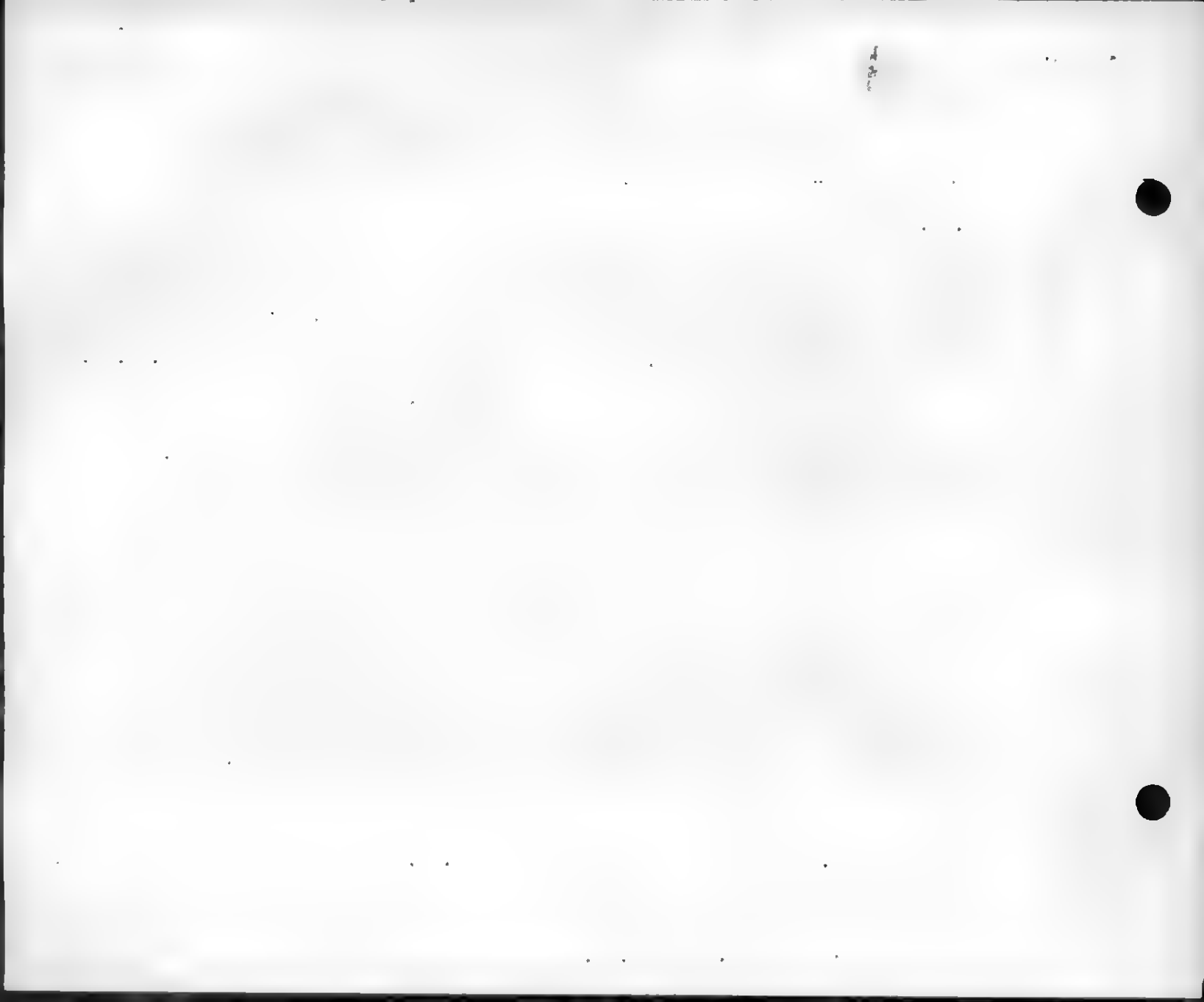
**CERTIFICATE OF DEATH**

02491

02451

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2 USUAL RESIDENCE (Where deceased lived if instit. an Residence before admission) a. STATE <b>Washington, D. C.</b> b. COUNTY <input checked="" type="checkbox"/>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda, (rural)</b>			c. LENGTH OF STAY in 1b <b>32 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>2511 Palmer Place</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <b>Patrick</b> Middle <b>Francis</b> Last <b>FAGAN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 66</b>			
5 SEX <b>Male</b>		6 COLOR OR RACE <b>Cauc</b>		7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>21 August 1885</b>	
9 AGE (In years last birthday) <b>80</b> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Navy</b>		10b KIND OF BUSINESS OR INDUSTRY <b>U. S. Navy</b>		11 BIRTHPLACE (County & State, or foreign country) <b>South Boston, Mass</b>	
12 CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Thomas Fagan</b>			
14. MOTHER'S MAIDEN NAME <b>Mary Conroy</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes</b> <b>WW I</b>			
16 SOCIAL SECURITY NO <b>579 60 6171</b>		17. INFORMANT <b>Edith Leonard Washington, D. C.</b>				18. ADDRESS <b>5211 Palmer Place</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY <b>1550 IMMEDIATE CAUSE (a) Hepatoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <b>Jan. 19</b> , 19 <b>66</b> , to <b>Feb. 20</b> , 19 <b>66</b> that (X) (we) last saw the deceased alive on <b>Feb. 20</b> , 19 <b>66</b> , and that death occurred at <b>4:20A</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>V. N. Polglase</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>21 Feb 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>V. N. Polglase LCDR MC USN</b>				22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb 24-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>	
24 FUNERAL DIRECTOR <b>Simmons Bros.</b>				1661 Good Hope Rd. Washington, D. C.		25a. REC'D BY REGISTRAR <b>FEB 23 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in all cases, within 72 hours after death.





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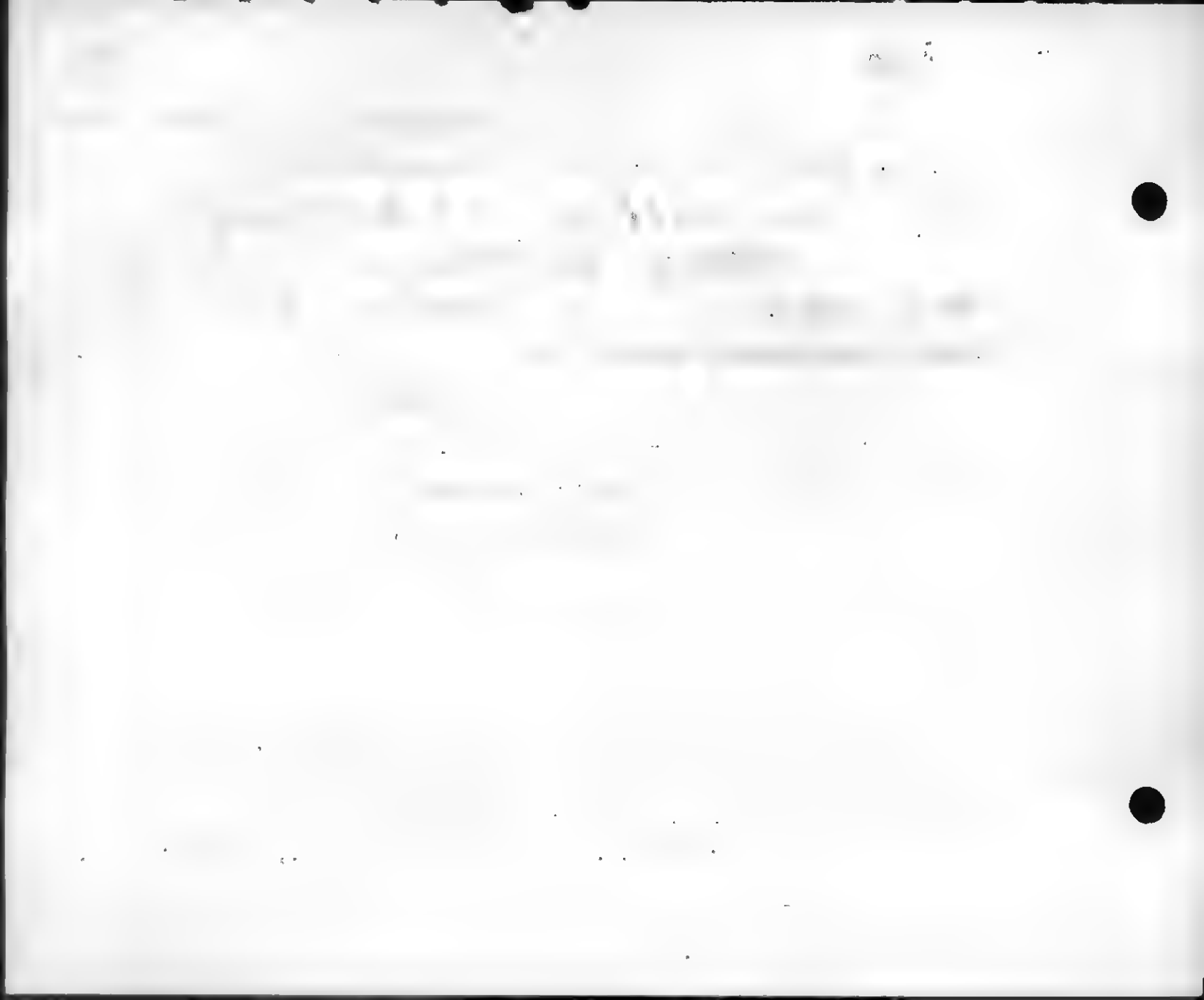
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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>PRINCE GEORGES</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>GREENBELT</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>HOLY CROSS HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>NORMAN</b> Middle <b>WALTER</b> Last <b>FARMER</b>		4. DATE OF DEATH Month <b>2</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/26/14</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Super-Market</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hecht Co</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>
13. FATHER'S NAME <b>John Edward Farmer</b>		14. MOTHER'S MAIDEN NAME <b>Florence Bussey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) <b>None</b>		16. SOCIAL SECURITY NO. <b>578-10-4136</b>	17. INFORMANT <b>Elsie O. Farmer</b> Address <b>2-G Northway Greenbelt, Maryland</b>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral metastasis</b> DUE TO (b) <b>Bronchogenic carcinoma</b> DUE TO (c) <b>2 mos.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>8 mos.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>1964</b> to <b>Feb 2, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 2, 1966</b> , and that death occurred at <b>5:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Henry Wolfe</b>		22b. DATE SIGNED <b>2/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Henry Wolfe, M.D.</b>		22d. ADDRESS <b>905 Sheridan St., Hyattsville, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-5-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D. C.</b>
24. FUNERAL DIRECTOR <b>Thomas E. Humphrey</b>		25a. REC'D BY REGISTRAR <b>8434 Georgia S.E.D.</b>	25b. REGISTRAR'S SIGNATURE <b>William J. Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 7 be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

02493

## CERTIFICATE OF DEATH

02453

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Naithersburg</u>	
c. LENGTH OF STAY IN TB <u>DOA</u>		d. STREET ADDRESS <u>R# 2 Box 92</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Garland</u> Last <u>Fink</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 24, 1888</u> 77 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Custodian</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rockingham Co, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Michael Fink</u>		14. MOTHER'S MAIDEN NAME <u>Martha Cullers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Heart Disease</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause as: (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1962</u> , 19 <u>62</u> , to <u>Feb 13, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 11, 1966</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Luciano I. Leal</u> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Luciano I. Leal</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-16-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Luke's Lutheran</u>		23d. LOCATION (City, town or county) (State) <u>Redland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 15 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

Libert Island

1900

1900

Cleared medical examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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# MARYLAND STATE DEPARTMENT OF HEALTH

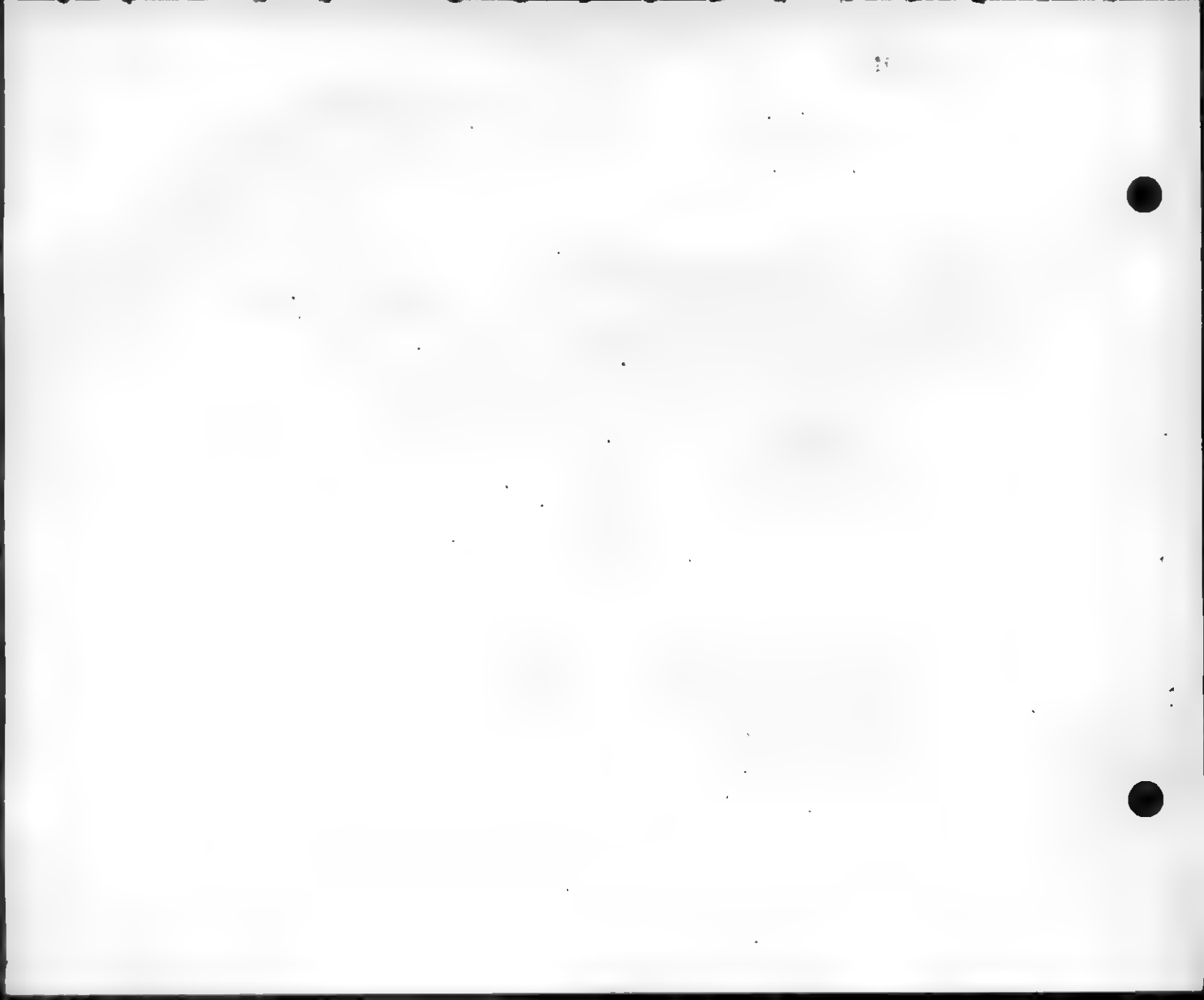
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02494

02455

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>2 1/2 hours</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1209 NORTH BELGRADE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARLES F. HINTER</u> First Middle Last 4. DATE OF DEATH <u>2</u> <u>6</u> <u>1966</u> Month Day Year				5. SEX <u>M</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>5/29/89</u> 9. AGE (in years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired from Bethlehem Steel Co.</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Pennsylvania</u> 11. BIRTHPLACE (County & State, or foreign country) <u>USA</u> 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>UNKNOWN</u> 14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>UNKNOWN</u> 17. INFORMANT <u>BETTE VUCCI</u> Address <u>1204 BELGRADE SILVER SPRING, MD</u>				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cerebral metastasis</u> DUE TO (c) <u>carcinoma of the lung</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mo's</u> <u>6 mo's</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 6</u> , 19 <u>66</u> , to <u>Feb 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 6</u> , 19 <u>66</u> , and that death occurred at <u>9:25 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Harold W. Draper</u> 22c. PHYSICIAN'S NAME (Type) <u>HAROLD W. DRAPER</u> 22b. DATE SIGNED <u>Feb 6, 1966</u> 22d. ADDRESS <u>10620 Georgia Ave, Silver Spring, MD</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>2-8-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>EBENEZER</u> 23d. LOCATION (City, town or county) (State) <u>LEBANON, PA.</u>				24. FUNERAL DIRECTOR <u>W. W. CHAMBERS</u> ADDRESS <u>8655 9th AVE</u> 25a. REC'D BY REGISTRAR <u>FEB 9 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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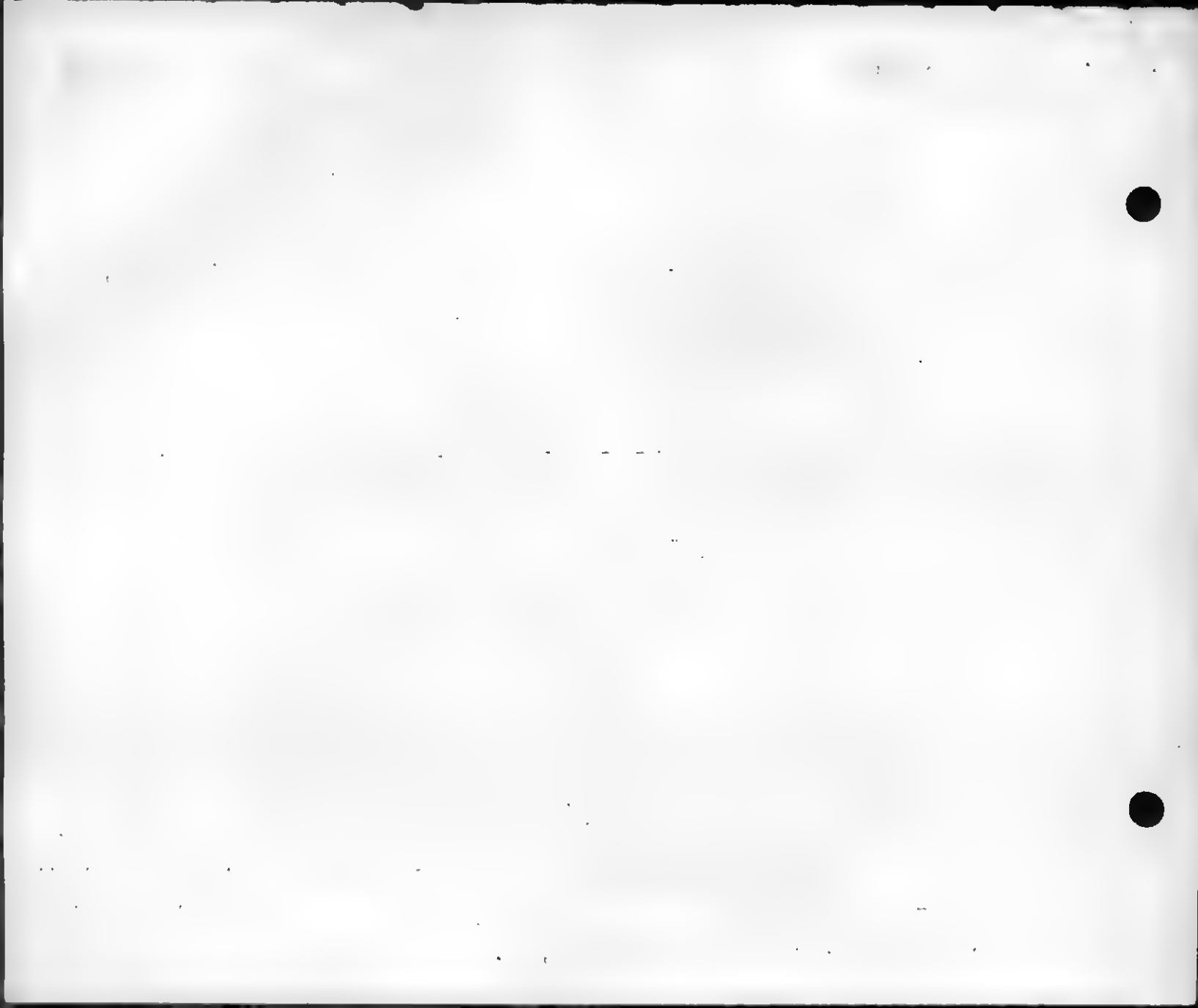
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02495

02456

1. PLACE OF DEATH a. COUNTY Montgomery			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 DeBeck Drive			d. STREET ADDRESS 2 Cedar Court		
3. NAME OF DECEASED (Type or print) First Middle Last Hazel V. Floyd			4. DATE OF DEATH Month Day Year Feb. 19, 1966		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/25/1886	9. AGE (In years last birthday) Months Days 79 yrs. Nov 25	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME Flynn		
14. MOTHER'S MAIDEN NAME White			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		
16. SOCIAL SECURITY NO. 403-28-3909			17. INFORMANT Mrs. George Parrish -same address above		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5711 Gastrointestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gastroenteritis (c)					INTERVAL BETWEEN ONSET AND DEATH 12 hours 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 14, 1966, to Feb 19, 1966, that (I) (we) last saw the deceased alive on Feb 19 1966, and that death occurred at 12:45 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Stephen C. Cromwell			22b. DATE SIGNED 2-20-66		
22c. PHYSICIAN'S NAME (Type) Stephen Cromwell			22d. ADDRESS 615 W. Montgomery Ave., Rockville, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/20/66		23c. NAME OF CEMETERY OR CREMATORY Louisville, Kentucky	
24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home Rockville, Md.			25a. REC'D BY REGISTRAR FEB 23 1966		
25b. REGISTRAR'S SIGNATURE Charles George					





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02496

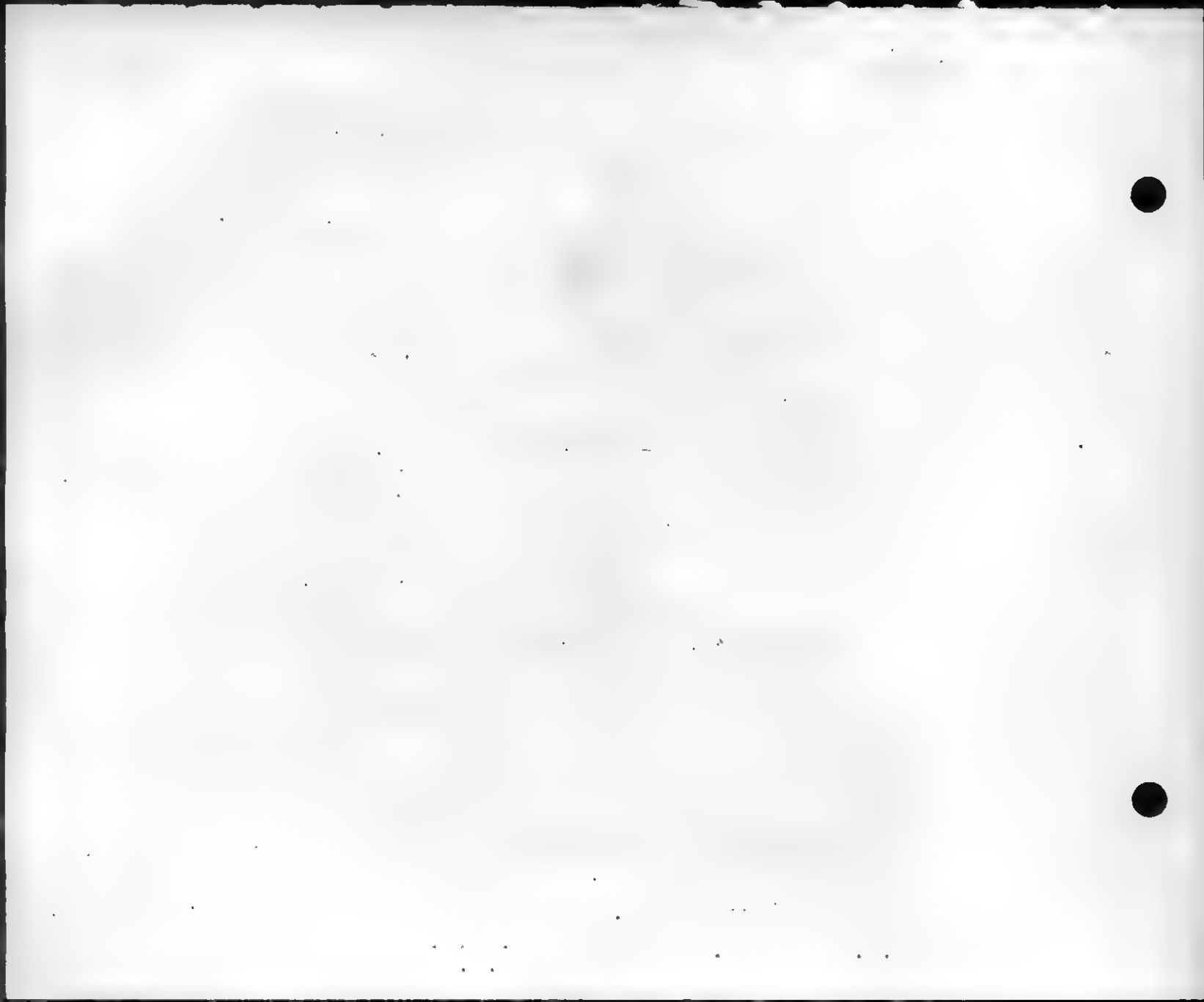
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02457

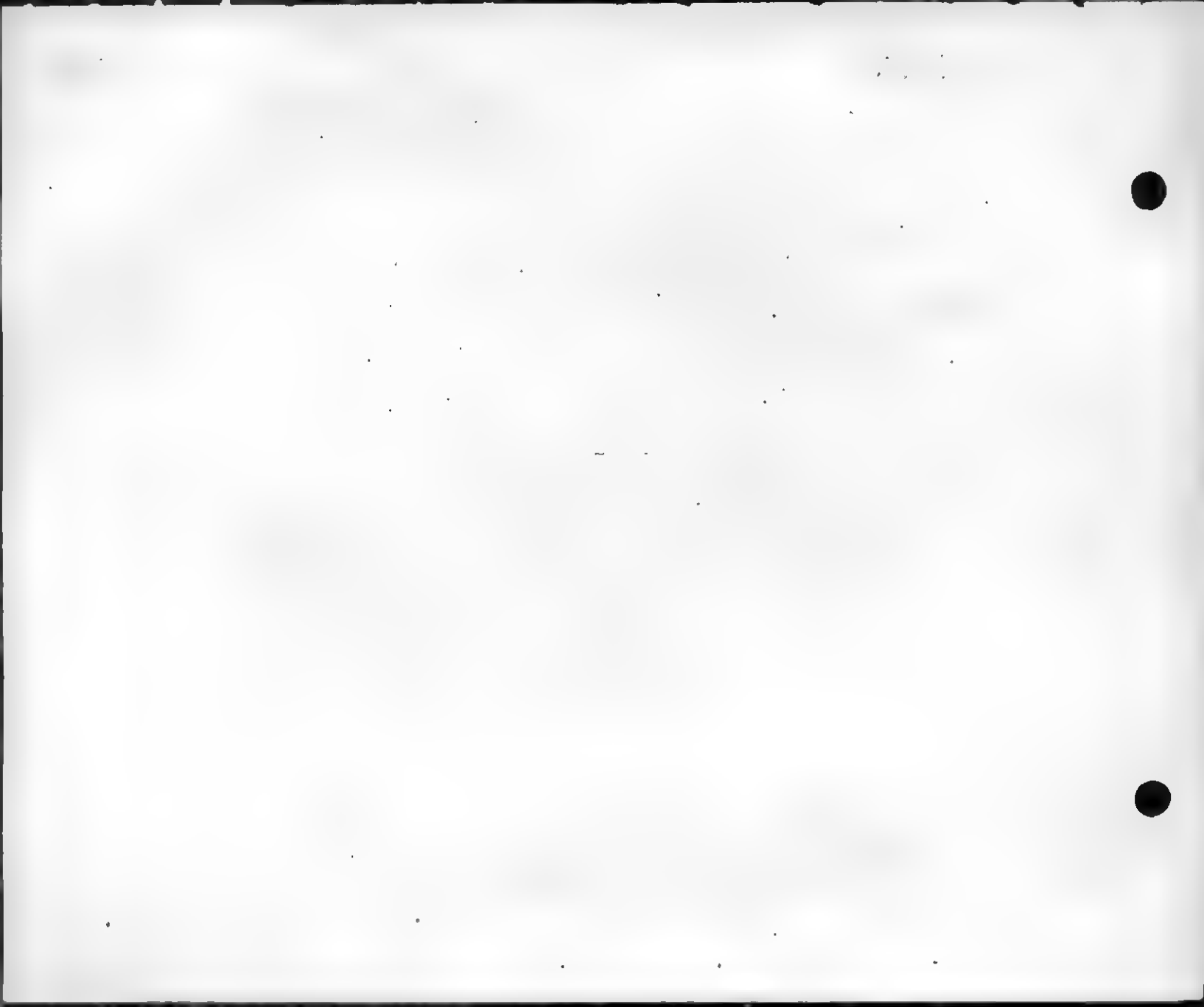
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BURTONSVILLE</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN ID <u>38 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL</u>				d. STREET ADDRESS <u>14000 Columbia Pike</u>			
3. NAME OF DECEASED (Type or print) First <u>ROBERT</u> Middle <u>NIXON</u> Last <u>FLOYD</u>				4. DATE OF DEATH Month <u>2</u> Day <u>9</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/26/94</u>	
9. AGE (in years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICE DEPT. &amp; TEL. CO. (RETIRED)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>VA.</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William Richard Floyd</u>				14. MOTHER'S MAIDEN NAME <u>Ida Carruthers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>577-30-5067</u>			
17. INFORMANT <u>Margaret S. Floyd</u>				Address <u>same as #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure, acute</u> DUE TO (b) <u>Hypertensive - arteriosclerotic</u> DUE TO (c) <u>Cardiovascular Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intestinal Obstruction (Jejunum)</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1966</u> to <u>Feb 9, 1966</u> , that (I) <del>was</del> last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>8 P</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Bernard A Fitzgerald</u>				22b. DATE SIGNED <u>2-9-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>BERNARD A FITZGERALD</u>				22d. ADDRESS <u>217 University Blvd SE Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>2/12/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges County, Md</u>	
24. FUNERAL DIRECTOR <u>The S.H. Hines Co.</u>				25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				25c. DATE <u>FEB 14 1966</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02497 CERTIFICATE OF DEATH 02458											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>26 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hyattsville</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> d. STREET ADDRESS <u>1502 Jefferson St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Arthur Hartman Ford</u> First Middle Last						4. DATE OF DEATH <u>Feb. 12 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4-16-03</u> yrs.		9. AGE (In years last birthday) <u>62</u> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>Walter Ford</u>						14. MOTHER'S M maiden name <u>Martha Forman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-44-7223</u>		17. INFORMANT <u>Hospital Records</u> Address					
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lic coronary occlusion, infarct</u> <u>4-1</u> DUE TO <u>followed by second attack</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>2/12/66</u> DUE TO <u>second attack was sudden death</u> (c) <u>immediately</u>										INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>1/26/66</u> , 19 <u>66</u> , to <u>2/12/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>11:30</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Chas H Wolshon, M.D.</u>						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolshon, M.D.</u>			
22d. ADDRESS <u>831 Union Blvd Gt Falls, Va</u>						22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cem</u>		23d. LOCATION (City, town or county) (State) <u>Cothman, Va</u>			
24. FUNERAL DIRECTOR <u>Nalley's Funeral Home Inc.</u>				24a. ADDRESS <u>Mt. Rainier Maryland</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 02498 CERTIFICATE OF DEATH 02459											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>8 months</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u> d. STREET ADDRESS <u>1155-11th Ave. N.W.</u> b. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>EDITH</u> Middle <u>Y.</u> Last <u>FORD</u>			4. DATE OF DEATH Month <u>FEBRUARY</u> Day <u>3</u> Year <u>1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-7-75</u>			9. AGE (In years last birthday) <u>90</u> yrs.			IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Samuel Simonds</u>						14. MOTHER'S MAIDEN NAME <u>Margaret Marks</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>None</u>					
17. INFORMANT <u>Paul E. Browning</u> Address <u>17-Parkway, Fount. Hgts. Md.</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>GENERALIZED ARTERIOSCLEROSIS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>SENILITY</u> INTERVAL BETWEEN ONSET AND DEATH <u>15 MIN.</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>DEC. 17, 1965</u> to <u>FEB. 3, 1966</u> , that (I) (we) last saw the deceased alive on <u>FEB. 3, 1966</u> , and that death occurred at <u>9:45 M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry J. Lowder</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED <u>2/3/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>LOWDER</u>						22d. ADDRESS <u>5206 Norway Dr. Chevy Chase, Md.</u>					
23a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2-8-66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		
24. FUNERAL DIRECTOR <u>W.W. Chambers &amp; Co.</u> ADDRESS <u>517-11th St. N.E.</u>						25a. REC'D BY REGISTRAR <u>FEB 8 1966</u>			25b. REGISTRAR'S SIGNATURE <u>W. W. Chambers</u>		

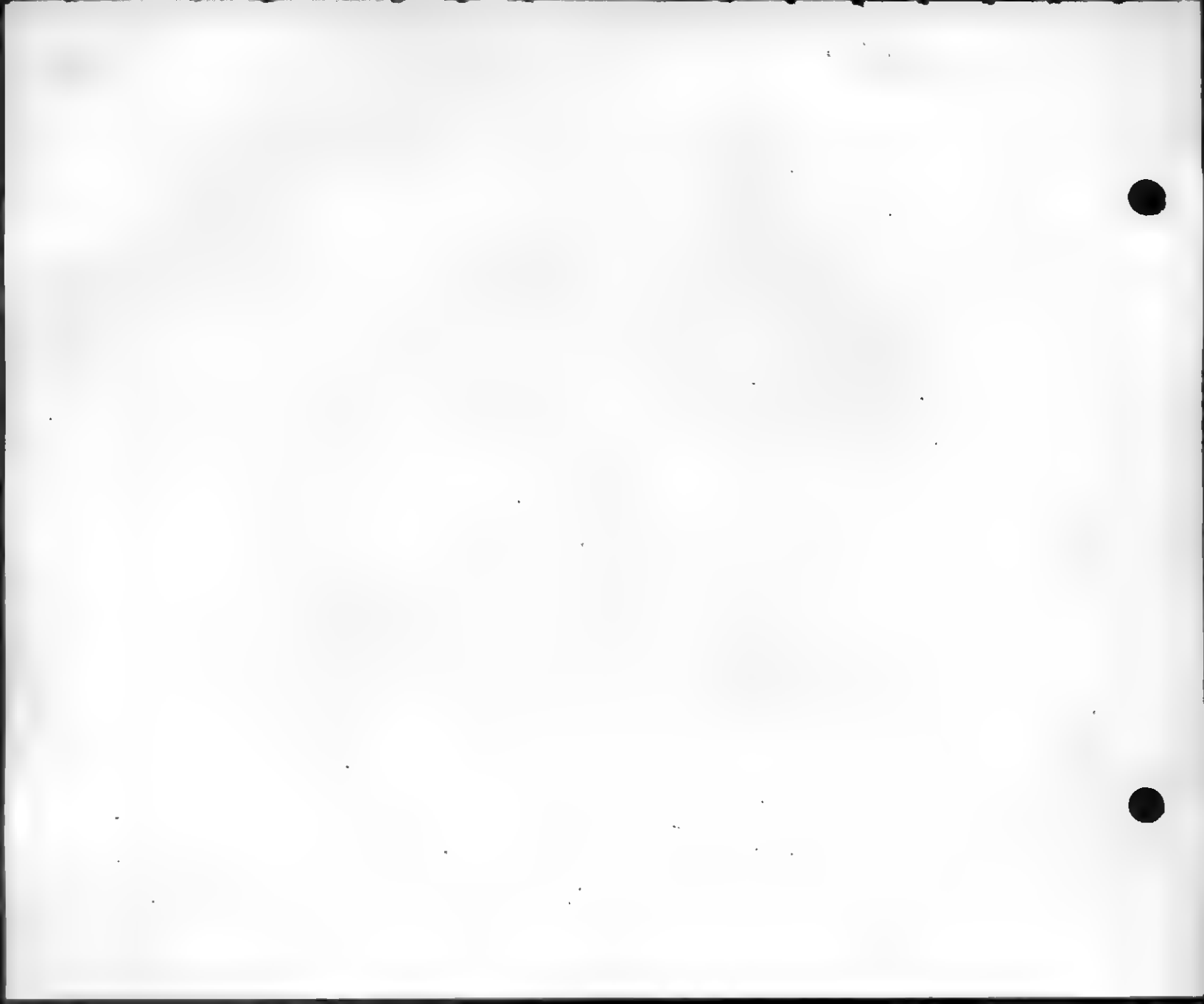


**HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02499						02460					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>MONTGOMERY</u>			b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			a. STATE <u>MARYLAND</u>			b. COUNTY <u>MONTGOMERY</u>		
c. LENGTH OF STAY IN 1b <u>46 days</u>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Maryland</u>			d. STREET ADDRESS <u>8124 Hamilton Spring Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>											
3. NAME OF DECEASED (Type or print) <u>GRACE F. FULLER</u>			4. DATE OF DEATH <u>Feb 16 1966</u>			5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>6-2-02</u>			9. AGE (In years last birthday) <u>63 yrs.</u>			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		
10b. KIND OF BUSINESS OR INDUSTRY <u>MANUFACTURING</u>			11. BIRTHPLACE (County & State, or foreign country) <u>MASS.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
13. FATHER'S NAME <u>BERNARD FARRELL</u>						14. MOTHER'S MAIDEN NAME <u>ANNIE SULLIVAN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>None</u>			17. INFORMANT <u>CHARLES E. GROENE</u>			Address <u>BETHESDA MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>174X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Adenocarcinoma of uterus</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>											
INTERVAL BETWEEN ONSET AND DEATH <u>9 mo.</u> <u>1 yr</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1965, to <u>Feb 16</u> , 1966, that (I) (we) last saw the deceased alive on <u>Feb 15</u> , 1966, and that death occurred at <u>8:25 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>John Lawrence Avery</u>						22b. DATE SIGNED <u>2/16/1966</u>					
22c. PHYSICIAN'S NAME (Type) <u>JOHN LAWRENCE AVERY</u>						22d. ADDRESS <u>10110 Georgia Ave., Silver Spring Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>2/21/66</u>			23c. NAME OF CEMETERY OR CREMATORY <u>MT. BENEDICT Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Boston, Mass.</u>		
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, Inc., Silver Spring, MD</u>						25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



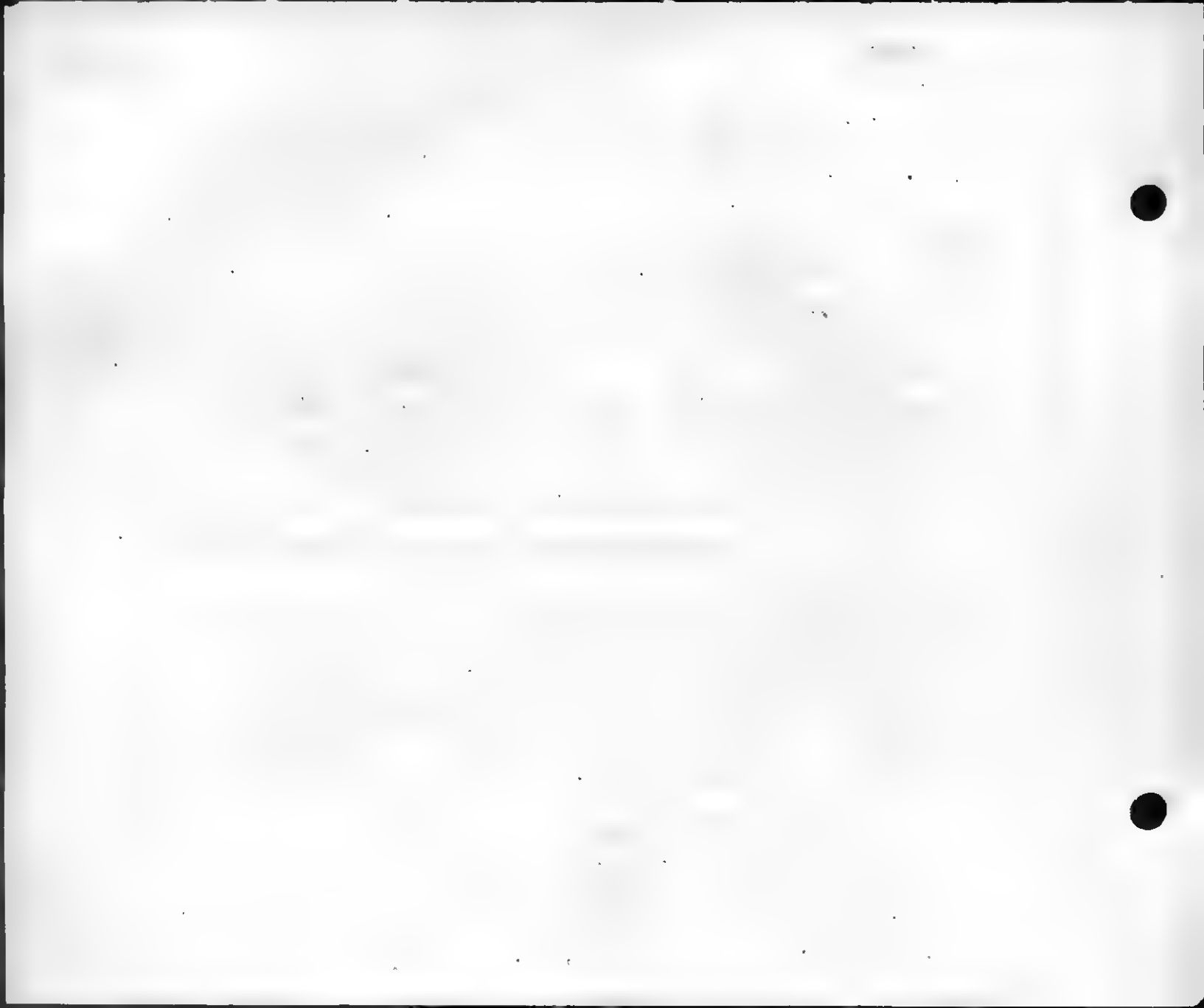


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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN 1b <i>29</i>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Prince Georges</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>West Hyattsville</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Sen &amp; Hospital</i>						d. STREET ADDRESS <i>5614 Chillum Rd.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Antonia Mariana Fuste</i>		4. DATE OF DEATH <i>2-10-1966</i>		5. SEX <i>Male</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>9-12-87</i>	
9. AGE (In years last birthday) <i>78</i> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Cuba</i>		12. CITIZEN OF WHAT COUNTRY? <i>Cuba</i>		13. FATHER'S NAME <i>Pedro Pedro Fuste</i>	
14. MOTHER'S MAIDEN NAME <i>Marie Viel</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NONE</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Hospital Records</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL HEMORRHAGE</i> <i>2923</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>MYELOPROLIFERATIVE DISEASE (MYELOFIBROSIS)</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 days</i> <i>SEV. YEARS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
21c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				21d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		21e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		21f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>1/13</i> , 19 <i>66</i> , to <i>2/10</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>2/10</i> , 19 <i>66</i> , and that death occurred at <i>6:35</i> A.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Richard H. Pollen</i>						22b. DATE SIGNED <i>2/11/66</i>		22c. PHYSICIAN'S NAME (Type) <i>RICHARD H. POLLEN</i>		22d. ADDRESS <i>10511 SUMMIT AVE, KENSINGTON MD</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Feb 12, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>		23d. LOCATION (City, town or county) (State) <i>Wheaton Md.</i>		24. FUNERAL DIRECTOR <i>F. Gasch's Sons</i>		25a. REC'D BY REGISTRAR <i>FEB 14 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>W. J. Judge</i>											



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>02501</b> <b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <b>MARYLAND</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village</u> c. LENGTH OF STAY IN lb <u>30 years +</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1215 Mass. Ave.,</u>						<b>02462</b> <b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Yorktown Village, Md. (Washington)</u> d. STREET ADDRESS <u>521, Mass. Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Josephine</u> First <u>C.</u> Middle <u>Gager</u> Last <b>4. DATE OF DEATH</b> <u>Feb</u> Month <u>13</u> Day <u>19</u> Year <u>66</u>						<b>5. SEX</b> <u>Female</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Nov. 11, 1823</u> <b>9. AGE</b> (in years last birthday) <u>72</u> yrs. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>					
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Medical</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Social Worker</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>						<b>13. FATHER'S NAME</b> <u>Charles B. Chapman</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Frances Chatterton</u>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>?</u> <b>17. INFORMANT</b> <u>John C. Gager, (same as Item 1.)</u> Address <u>Ser.</u>											
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Hypertensive heart disease</u> DUE TO (c) <u>with cardiomegaly</u> <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> <b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1960</u> , 19 <u>  </u> , to <u>Feb 9, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>4 PM</u> , from the causes and on the date stated above. <b>22a. SIGNATURE</b> <u>C P Ryland</u> <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>C P RYLAND</u> <b>22d. ADDRESS</b> <u>4400-49 St NW Wash DC 20016</u> <b>22b. DATE SIGNED</b> <u>2-13-66</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>23b. DATE THEREOF</b> <u>Feb. 16, 1966</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington, Natl.</u> <b>23d. LOCATION (City, town or county)</b> (State) <u>Arlington, Virginia</u> <b>24. FUNERAL DIRECTOR</b> <u>H. Don. DeVol</u> ADDRESS <u>Wash. D.C.</u> <b>25a. REC'D BY REGISTRAR</b> <u>2224 Wis. Ave.</u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>FEB 16 1966</u> <u>J. M. Jones</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

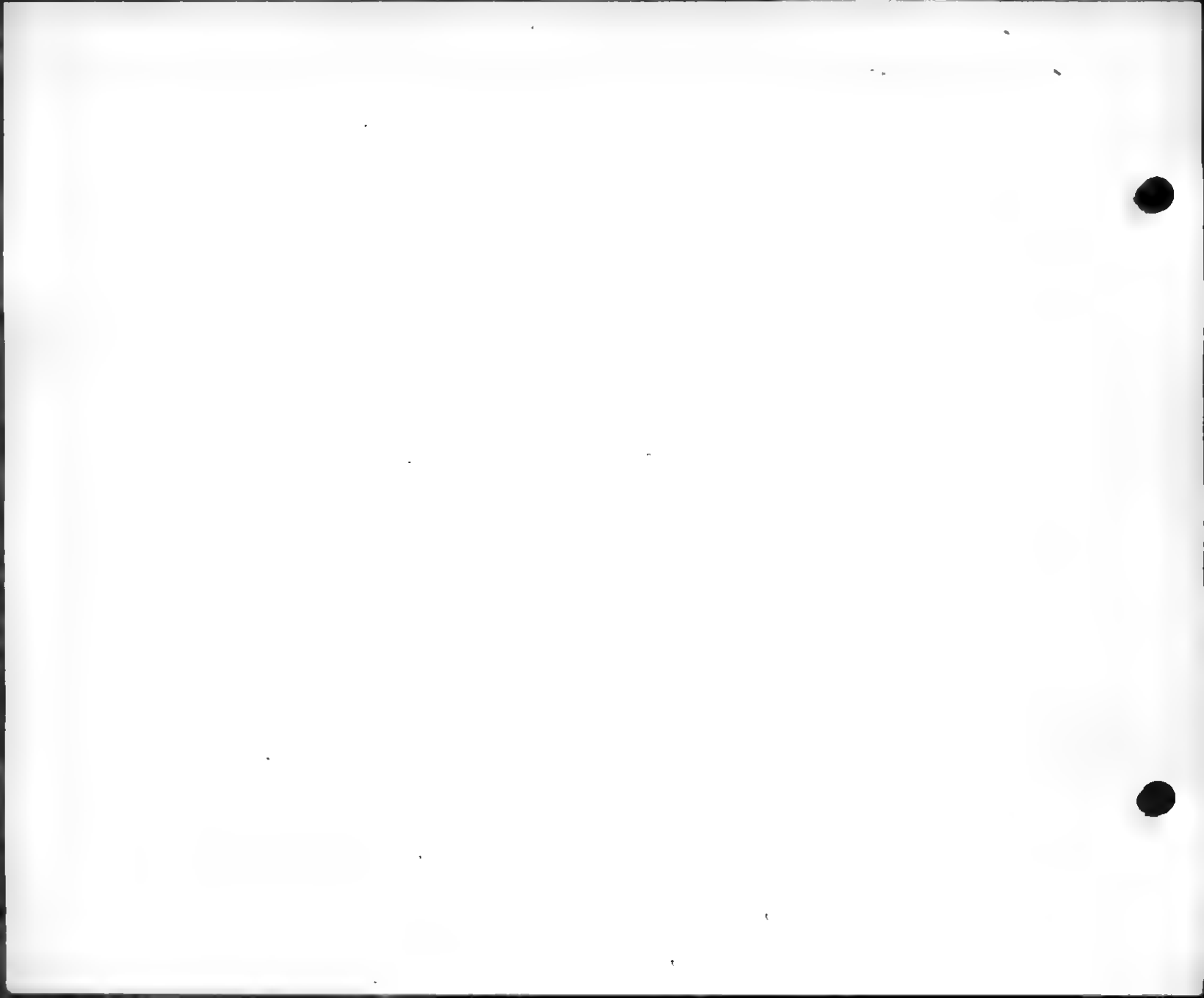
02502

02463

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u> c. LENGTH OF STAY IN <u>2 mo 27 da</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington Gardens</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince Georges</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Temple Hills</u> d. STREET ADDRESS <u>5130 Fisher Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Samuel</u> First <u>L. Gardiner</u> Middle <u>L.</u> Last <u>Gardiner</u> DATE OF DEATH <u>Feb. 15 1966</u>				<b>5. SEX</b> <u>MALE</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 26 1884</u> <b>9. AGE</b> (In years last birthday) <u>81</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wash Navy</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>District of Columbia U.S.A</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Samuel L. Gardiner</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unk</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <u>Geo E. Gardiner 6013-27444</u>		<b>17. INFORMANT</b> Address	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic heart disease</u> (b) <u>generalized arteriosclerosis</u> (c) <u>consequences of prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO							INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u> <u>10 yrs</u>
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Nov 21, 1965</u> , to <u>Feb 15, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 15, 1966</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>[Signature]</u>				<b>22b. DATE SIGNED</b> <u>2/15/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>H F Kreuzburg</u>	
<b>22d. ADDRESS</b> <u>7852 16th St NW Wash DC 12</u>				<b>22e. M.D. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 18-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Washington National Cemetery</u>		<b>23d. LOCATION (City, town, or county) (State)</b> <u>Suitland, Maryland.</u>	
<b>24. FUNERAL DIRECTOR</b> <u>Simmons Bros.</u> ADDRESS <u>1661- Gd. Hope Rd. SE. Wash. DC.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>[Signature]</u> DATE <u>FEB 17 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>	

See page 10.



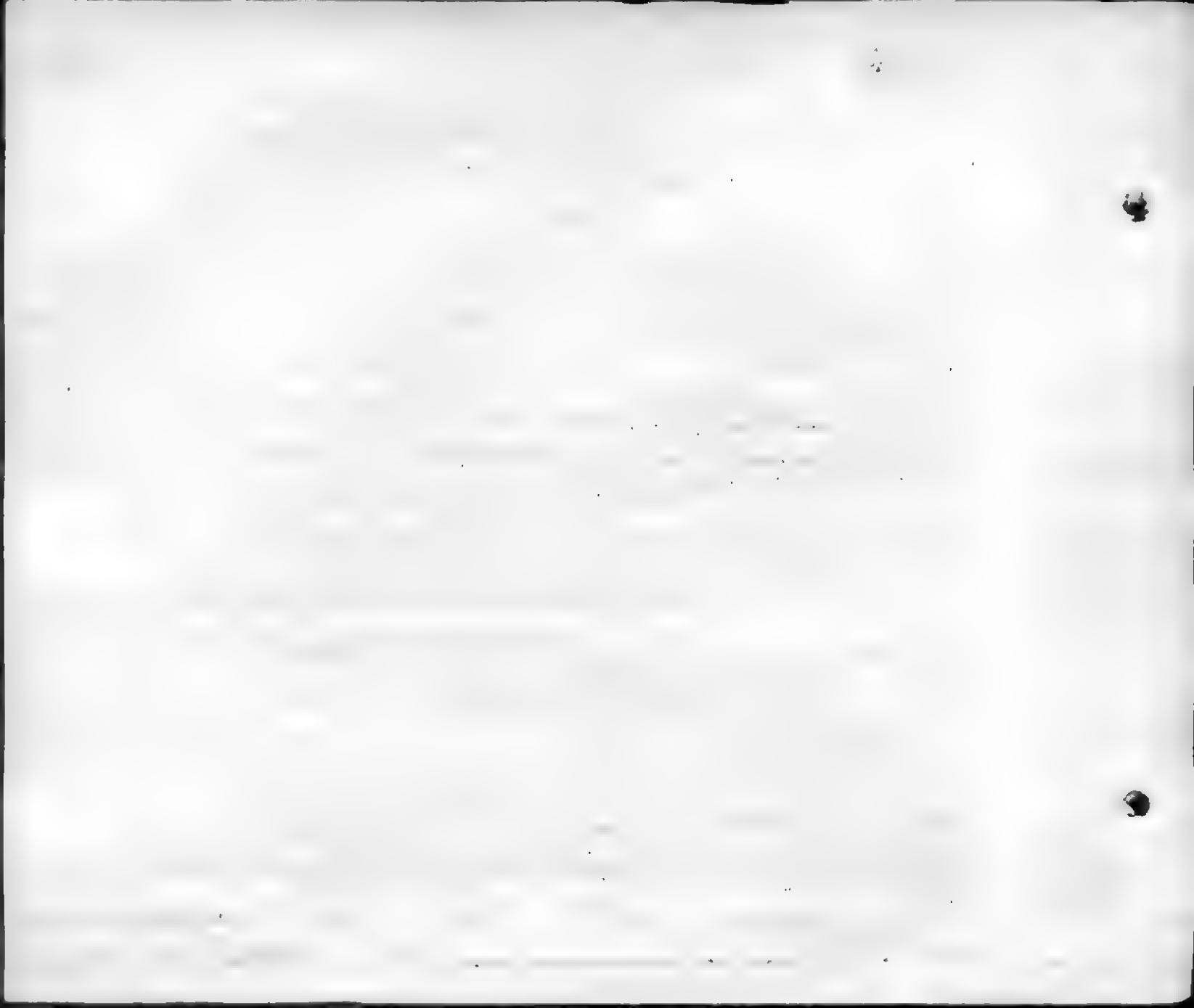




02504

02465

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) c. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN lb. <u>1 hr.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		e. STREET ADDRESS <u>2300 Parker Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>CLYDE (NMN) GEORGE</u>		4. DATE OF DEATH <u>Febr. 1, 1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-22-1914</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		9b. AGE (In years last birthday) <u>51</u> yrs.	
10a. KIND OF BUSINESS OR INDUSTRY <u>U. S. GOV'T</u>		10b. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
11. FATHER'S NAME <u>Ira George</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. MOTHER'S MAIDEN NAME <u>Lillie Kirby</u>		14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war/dates of service) <u>No</u>	
15. SOCIAL SECURITY NO. <u>574-18-8494</u>		16. INFORMANT <u>Mrs. Helen George (Wife)</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Acute Coronary Insufficiency</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Coronary Artery Heart Disease</u> DUE TO (c)		18. INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>Belden R. Read</u> M.D.		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
24. EXAMINER'S NAME (Type) <u>BELDEN R. READ M.D.</u>		25. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
26. DATE THEREOF <u>2-3-66</u>		27. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Wheaton</u> DATE SIGNED <u>Feb. 1, 1966</u>	
28. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		29. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cemetery</u>	
30. DATE THEREOF <u>2-3-66</u>		31. LOCATION (City, town, or county) (State) <u>Silver Spring, Maryland</u>	
32. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		33. ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>	
34. REC'D BY REGISTRAR <u>Charles Judge</u>		35. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
36. DATE <u>FEB 7 1966</u>		37. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02505

02466

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>P G.</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TRKONA PK</u>		c. LENGTH OF STAY IN 1b <u>36 hrs 45 min</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RD DELPHI</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SAN &amp; Hosp</u>				d. STREET ADDRESS <u>1814 METZEROTT</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>ELIZABETH</u> Last <u>GERARD</u>				4. DATE OF DEATH Month <u>2</u> Day <u>14</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-20-03</u>		9. AGE (in years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>62</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HIS WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN H RHODES</u>			14. MOTHER'S MAIDEN NAME <u>Jeannette Headley</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <u>Rob. Chase</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> DUE TO (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>3 YEARS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>12 HOURS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS SEVERE 15 YEARS</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE</u> , 19 <u>63</u> , to <u>2/14</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>66</u> , and that death occurred at <u>2:45</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Hugh W Irey</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>HUGH W IREY</u>				22d. ADDRESS <u>7105 - RIGGS RD, HYATTSVILLE, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>12-17-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven</u>		23d. LOCATION (City, town or county) (State) <u>Silver Spring MD</u>	
24. FUNERAL DIRECTOR <u>WATTLING Funeral Home, Washington, DC</u>				25a. REC'D BY REGISTRAR <u>FEB 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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02506

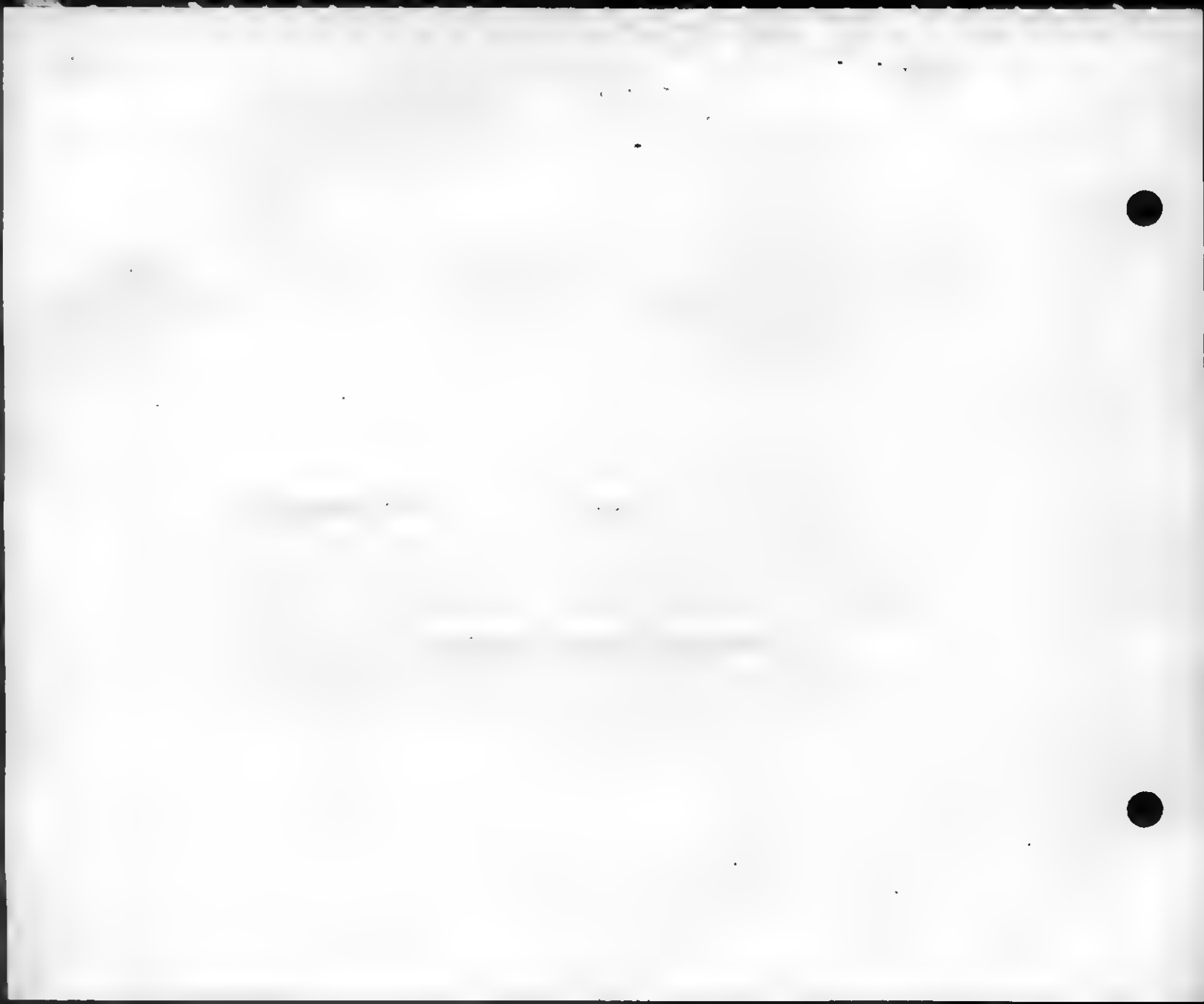
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN ID <u>10-2-65-2-7-66</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>University Nursing Home - Wheaton, Md.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>ELLA Mae GLOVER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>7</u> Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-19-73</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dress Maker Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fishes Eddy, New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANN, John</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Snook's</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs. Howard Pohl</u>		Address <u>1221 Remington Drive Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized arteriosclerosis</u> DUE TO (b) <u>  </u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinsonism</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from <u>10-3, 1965</u> , to <u>2-7, 1966</u> , that (we) last saw the deceased alive on <u>2-7-1965</u> , and that death occurred at <u>12:00</u> AM, from the causes and on the date stated above.	
22a. SIGNATURE <u>D. J. Sengstack M.D.</u>		22b. DATE SIGNED <u>2-7-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>D. J. Sengstack, M.D.</u>		22d. ADDRESS <u>9241 Columbia Blvd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>  </u>		23b. DATE THEREOF <u>2-9-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>East Ridge Lawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Delaware, New York</u>	
24. FUNERAL DIRECTOR <u>Charles E. Burnhough, Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. ADDRESS <u>8471 Morris Avenue Silver Spring, Md.</u>	









# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

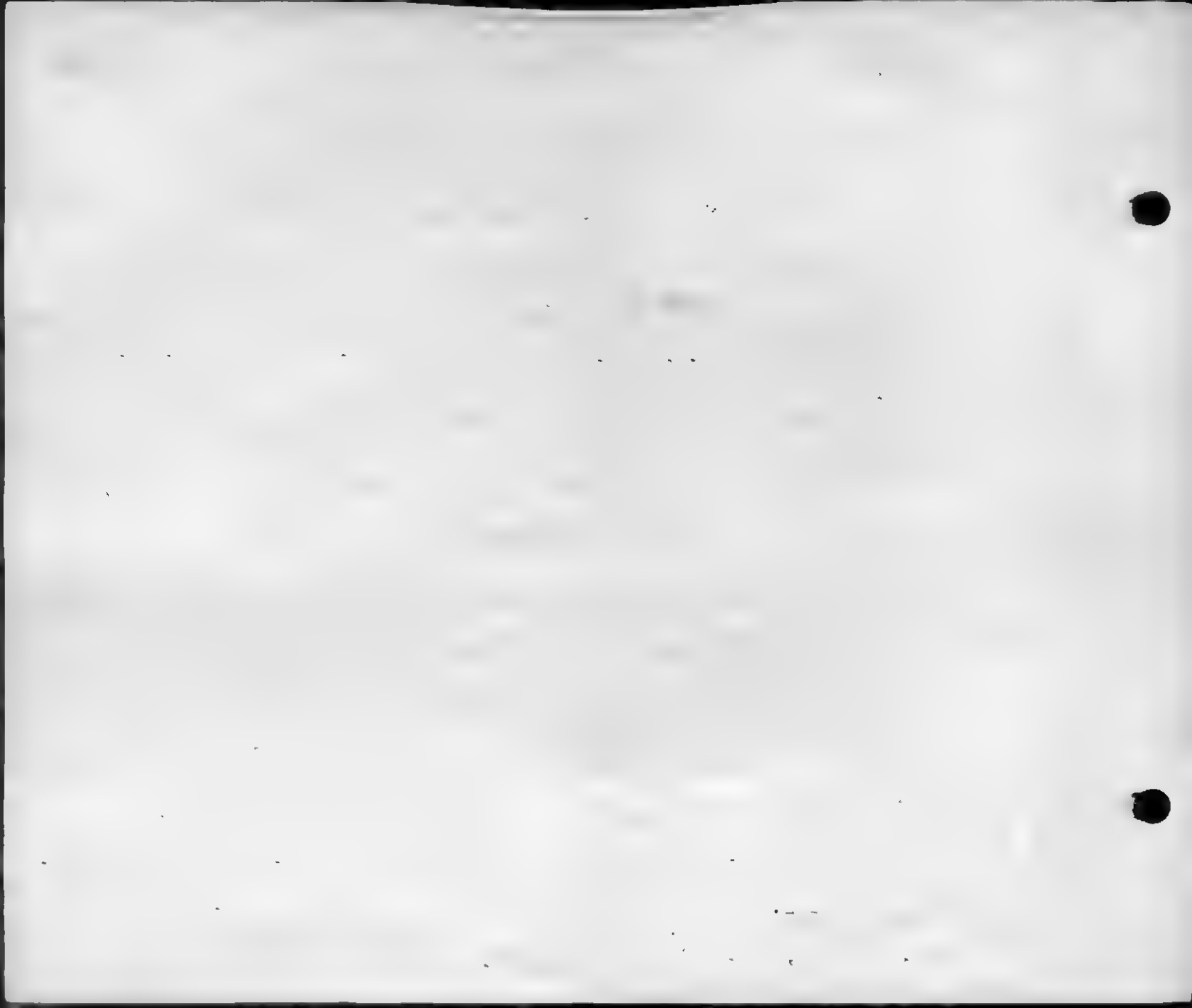
## CERTIFICATE OF DEATH

02508

02469

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b> c. LENGTH OF STAY IN 1b <b>9 months</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>United Church of Christ Home, Inc., 8505 Springdale Rd., Silver Spring, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b> d. STREET ADDRESS <b>8708 Colesville Rd.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <b>Shaul</b> First Middle Last		4. DATE OF DEATH <b>February 2 19 66</b> Month Day Year		5. SEX <b>F</b> M F		6. COLOR OR RACE <b>W</b> W B O		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>DIVORCED</b> <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 18, 1889</b> Month Day Year		9. AGE (In years last birthday) <b>76</b> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired personnel clerk</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Middleway, W. Virginia</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George R. Shaul</b>						14. MOTHER'S MAIDEN NAME <b>Katherine Murphy</b>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> None				16. SOCIAL SECURITY NO. <b>None</b>				17. INFORMANT <b>John Shaul</b> Address <b>121 Woodhall Road Bethesda, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>4201</b> DUE TO (b) <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <b>1957</b> to <b>2 Feb 1966</b> that (I) (we) last saw the deceased alive on <b>2 Feb 1966</b> and that death occurred at <b>1 P.M.</b> from the causes and on the date stated above.													
22a. SIGNATURE <b>William D. Cuff</b> M.D. 22c. PHYSICIAN'S NAME (Type) <b>William D. Cuff</b>												22b. DATE SIGNED <b>2-3-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>2-5-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Masonic Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Middleway, W. Virginia</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest E. Humphrey, Inc.</b> ADDRESS <b>8434 Georgia Avenue Silver Spring, Md.</b>						25. REC'D. BY REGISTRAR <b>FEB 7 1966</b> DATE		25b. REGISTRAR'S SIGNATURE <b>John W. Judge</b>					

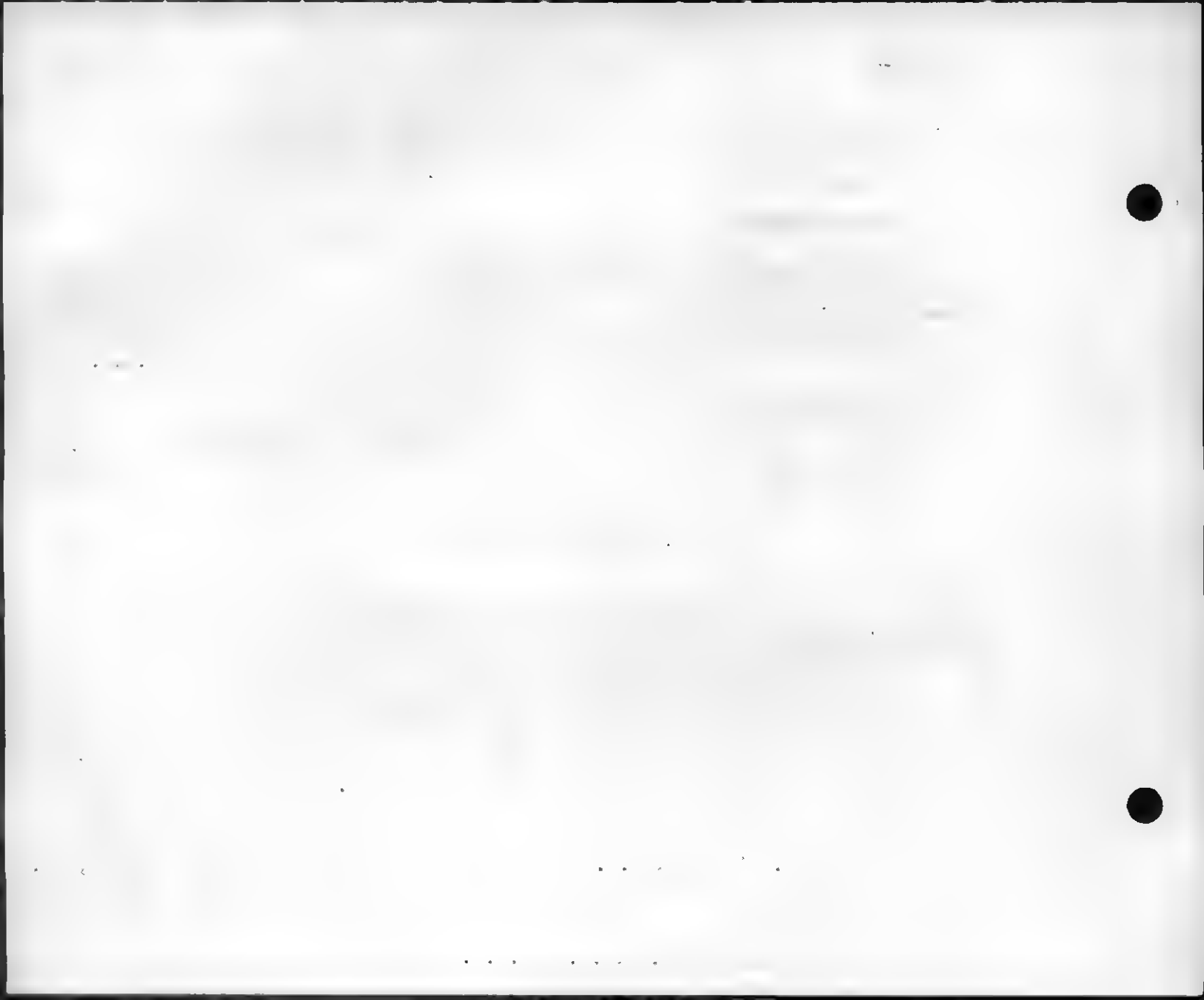
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>02509</b>						<b>02470</b>					
<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> <b>Montgomery</b>						<b>2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)</b> <b>a. STATE</b> <b>Florida</b>					
<b>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>Bethesda</b>						<b>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</b> <b>Ormond Beach</b>					
<b>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</b> <b>The Clinical Center</b>						<b>d. STREET ADDRESS</b> <b>11 Seaside Drive</b>					
<b>3. NAME OF DECEASED</b> <b>(Type or print)</b> <b>First Middle Last</b> <b>Maria Erhardina Greaves</b>						<b>4. DATE OF DEATH</b> <b>Month Day Year</b> <b>February 7 1966</b>					
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>September 18, 1892</b>		<b>9. AGE (In years last birthday)</b> <b>73 yrs.</b>		<b>IF UNDER 1 YEAR</b> <b>Months Days Hours Min.</b>	
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>None</b>				<b>11. BIRTHPLACE (County &amp; State, or foreign country)</b> <b>Sweden</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Klaus Rosengrin</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Maria Ringquist</b>					
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</b> <b>No</b>						<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> <b>The Medical Record</b>			
<b>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</b> <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a) Septicemia (Clinical)</b> <b>6926</b> <b>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b) Lower abdominal abscess</b> <b>(c)</b>											
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <b>Hemolytic Anemia years</b>											
<b>19. WAS AUTOPSY PERFORMED?</b> <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>months</b> <b>months</b>					
<b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b>					
<b>20c. TIME OF INJURY</b> Month, Day, Year <b>Hour</b> a.m. p.m. <b>19</b>				<b>20d. INJURY OCCURRED</b> <b>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></b>		<b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b>		<b>20f. (City or town) (County) (State)</b>			
<b>21. I certify that <del>XX</del> (this hospital) attended the deceased from <b>September 11, 1965</b>, to <b>February 7, 1966</b>, that <del>it</del> (we) last saw the deceased alive on <b>February 7, 1966</b>, and that death occurred at <b>4:15 PM</b>, from the causes and on the date stated above.</b>											
<b>22a. SIGNATURE</b> <b>Bert W. O'Malley</b>						<b>22b. DATE SIGNED</b> <b>7 February 1966</b>					
<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Bert W. O'Malley, M.D.</b>						<b>22d. ADDRESS</b> <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>					
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>BURIAL</b>			<b>23b. DATE THEREOF</b> <b>2/10/1966</b>			<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Fairview Cemetery</b>			<b>23d. LOCATION (City, town or county) (State)</b> <b>West Hartford, Connecticut</b>		
<b>24. FUNERAL DIRECTOR</b> <b>Garry S. Hysong</b>						<b>25a. REC'D BY REGISTRAR</b> <b>5-10 1966</b>					
<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. J. Jones</b>											
<b>HYSONG'S FUNERAL HOME 1300 N. ST., N.W. WASH. D.C.</b>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY.</b> c. LENGTH OF STAY IN 1b <b>4 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>MONTGOMERY GENERAL</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BROOKEVILLE</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <b>HARVEY</b> Middle <b>JOHN</b> Last <b>GREEN</b>			4. DATE OF DEATH Month <b>FEBRUARY</b> Day <b>12</b> Year <b>1966</b>						
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/24/85</b>		9. AGE (In years last birthday) <b>80</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer and carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN GREEN</b>					14. MOTHER'S MAIDEN NAME <b>REBECCA WEBER</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>217-32-1325</b>		17. INFORMANT <b>Hospital Records</b>			Address <b>Olney, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma, generalized</b> DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <b>14 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>6/1/8</b> , 19 <b>66</b> to <b>7/1/2</b> , 19 <b>66</b> , that (I) <del>was</del> last saw the deceased alive on <b>7/1/2</b> , 19 <b>66</b> , and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>James P. Kerr</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>7/12/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>James P. Kerr</b>					22d. ADDRESS <b>Damascus, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>2-16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel</b>		23d. LOCATION (City, town or county) (State) <b>Sunshine, Md.</b>		
24. FUNERAL DIRECTOR <b>Francis H. Barber</b> <b>Laytonsville, Md.</b>					25a. REC'D BY REGISTRAR <b>Feb 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02511

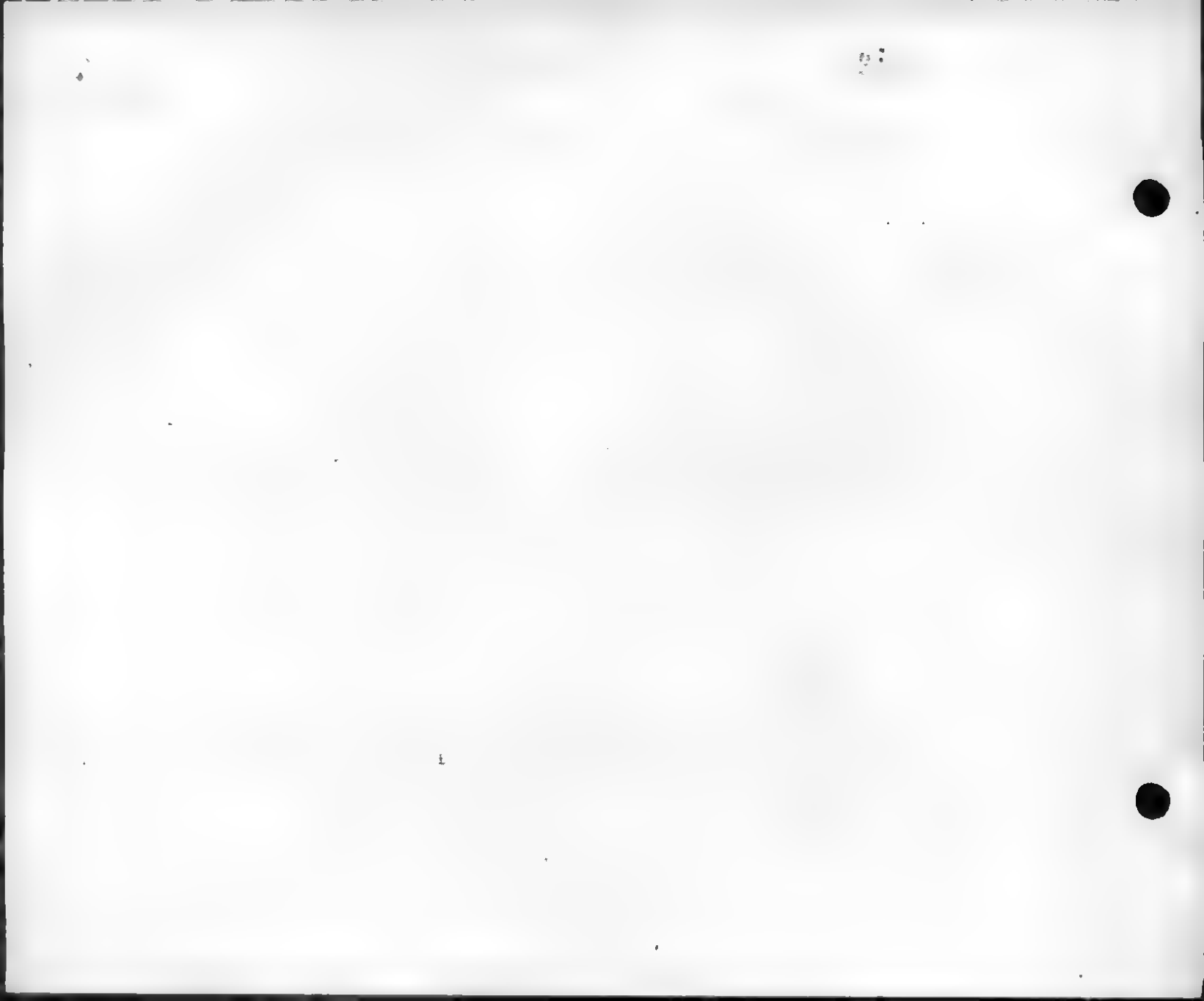
CERTIFICATE OF DEATH

02472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>New York</u> b. COUNTY	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda (Rural)</u>		c LENGTH OF STAY IN 1b <u>167 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>		d STREET ADDRESS <u>223 East LaFrance St.</u>	
3 NAME OF DECEASED (Type or print) First <u>Mervin</u> Middle <u>Albert</u> Last <u>GROSS</u>		4. DATE OF DEATH Month <u>February</u> Day <u>24</u> Year <u>19 66</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>Cauc</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>April 27, 1916</u>
9 AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Navy</u>		10b KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>John Daniel Gross</u>		14. MOTHER'S MAIDEN NAME <u>Emma C. Kraft</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>168-16-3556</u>	
17. INFORMANT <u>Mrs. Edith E. Gross, 223 East LaFrance St./</u>		Address <u>Elmira, N. Y.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Renal Cell Carcinoma with widespread metastases</u> <u>180x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>  </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> p.m. <u>  </u> 19 <u>  </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>	20f (City or town) (County) (State) <u>  </u>
21. I certify that (1) (this hospital) attended the deceased from <u>Sept. 10</u> , 19 <u>65</u> , to <u>Feb. 24</u> , 19 <u>66</u> that (1) (we) last saw the deceased alive on <u>Feb. 24</u> , 19 <u>66</u> , and that death occurred at <u>7:15 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>Feb. 24, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>F. J. Frensilli M.D.</u>		22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/25/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn National Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Elmira, New York</u>
24 FUNERAL DIRECTOR <u>W. W. Chambers Co., 1400 Chapin St., N.W.</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 28 1966</u>	
ADDRESS <u>Washington, D. C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

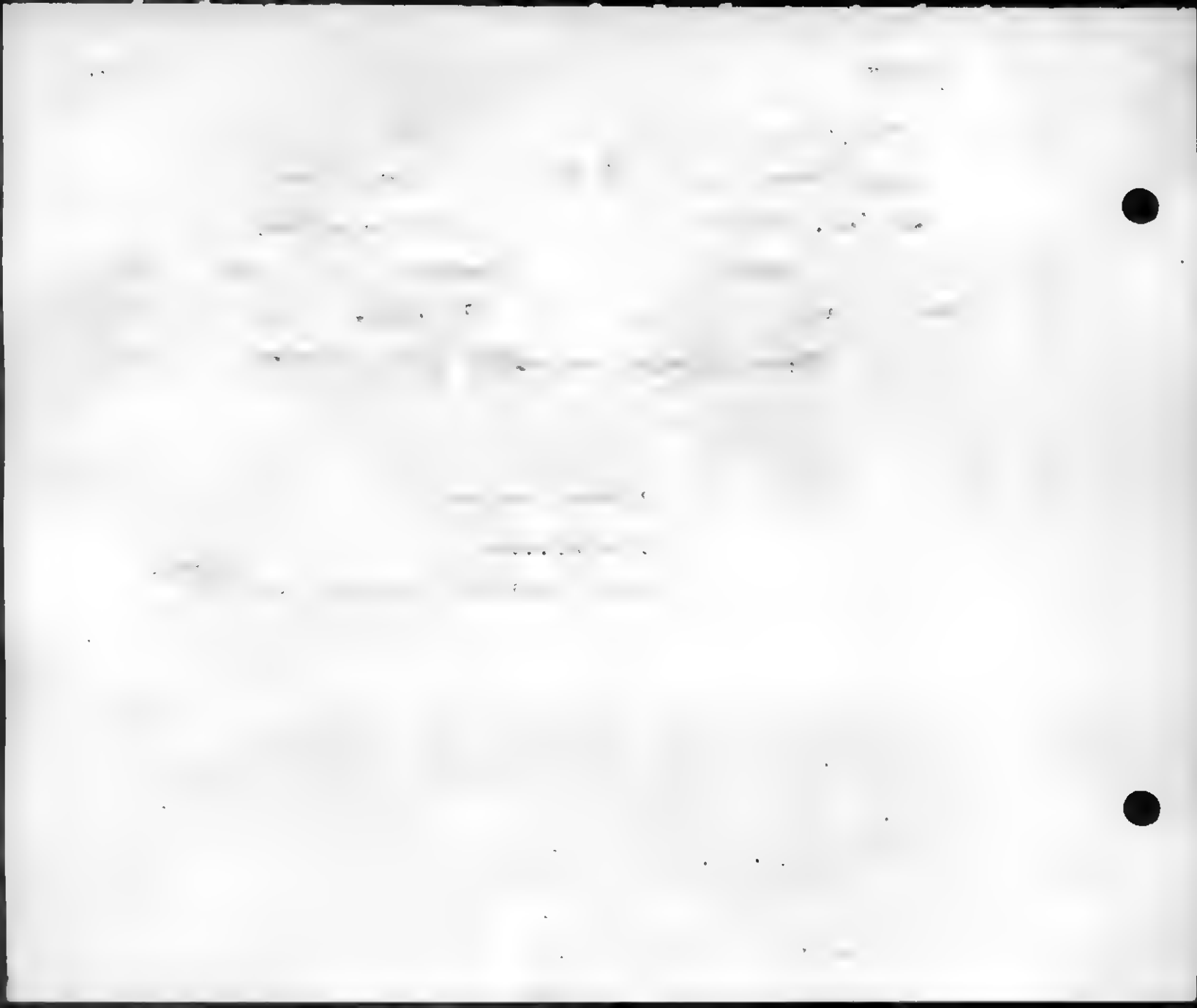
02512

CERTIFICATE OF DEATH

02473

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) b. STATE <b>md.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
c. LENGTH OF STAY IN ID <b>6 days</b>		d. STREET ADDRESS <b>9315 Crosby Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ERIC</b> Middle <b>T</b> Last <b>HAGBERG</b>		4. DATE OF DEATH Month <b>Feb</b> Day <b>20</b> Year <b>1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/12/16</b>
9. AGE (In years last birthday) <b>49 yrs.</b>		10. IF UNDER 1 YEAR Months <b>49</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STATE DEPARTMENT AND WASHINGTON</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary abscess</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral edema</b> DUE TO (c) <b>Healed myocardial infarction with mural thrombus</b>				INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <b>AUGUST, 1955</b> to <b>FEB. 20, 1966</b> , that (1) (I) last saw the deceased alive on <b>FEB. 20, 1966</b> , and that death occurred at <b>9:15 P.M.</b> from the causes and on the date stated above.				
22a. SIGNATURE <b>James A. Roberts</b>		22b. DATE SIGNED <b>2/20/66</b>		
22c. PHYSICIAN'S NAME (Type) <b>JAMES A. ROBERTS</b>		22d. ADDRESS <b>8907 GEO. AVE. SILVER SPRING, M.D.</b>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>2-22-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>	23d. LOCATION (City, town or county) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>DATE 2-24-1966</b>		25b. REGISTRAR'S SIGNATURE <b>Wm. J. Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

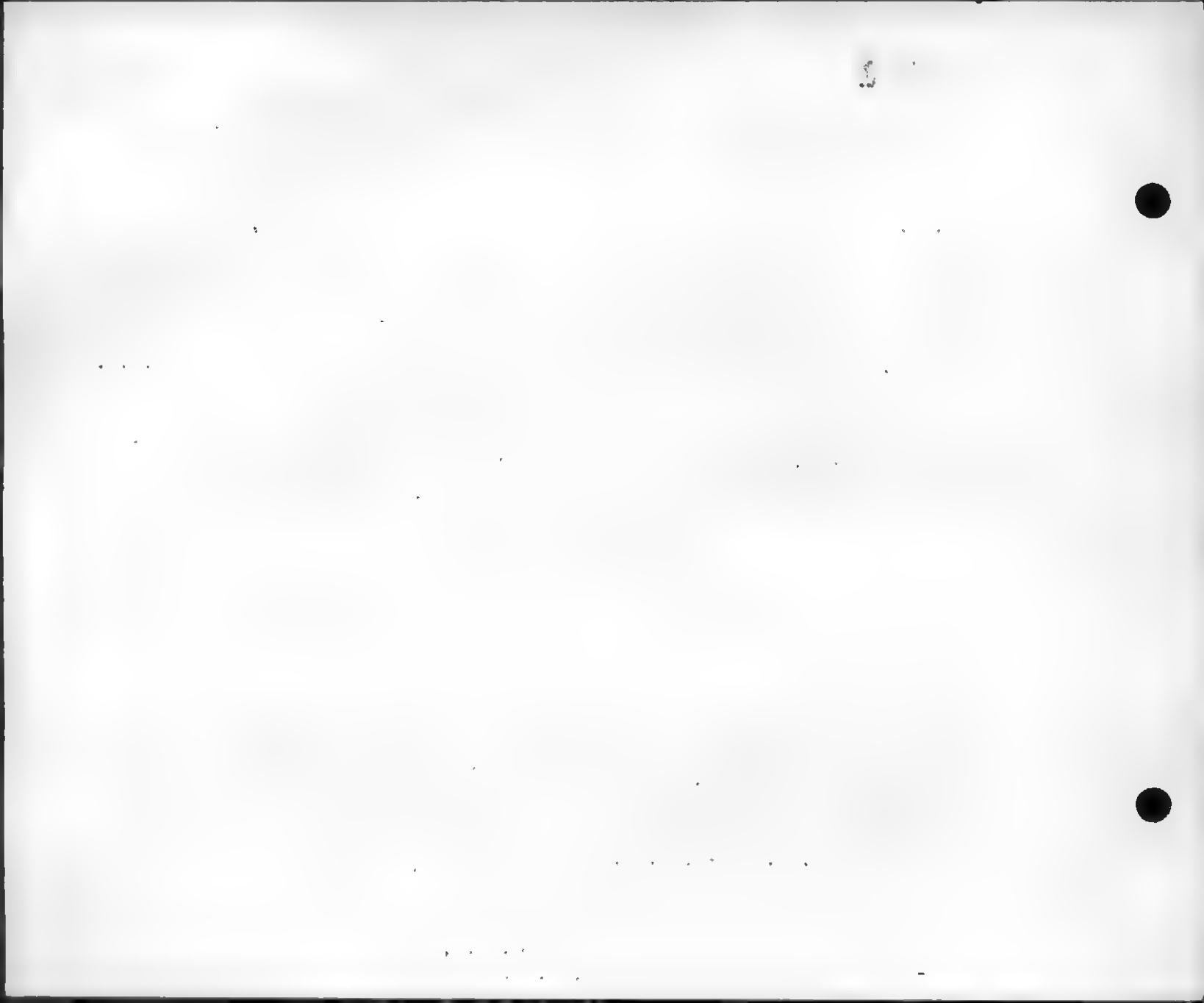
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02513

CERTIFICATE OF DEATH

02474

1. PLACE OF DEATH a. COUNTY Montgomery		b. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda (rural)		c. LENGTH OF STAY IN 1b 6 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda, (rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) U. S. Naval Hospital				d. STREET ADDRESS 5300 Ridgefield Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Robert Hair		First Middle Last		4. DATE OF DEATH February 8 19 66		Month Day Year	
5. SEX Male	6. COLOR OR RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 20, 1881	9. AGE (In years last birthday) 84 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U. S. Navy		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) New Florence, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Robert Hair				14. MOTHER'S MAIDEN NAME Rose Campbell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes Disch. 11-1-32		16. SOCIAL SECURITY NO. - - -		17. INFORMANT Mrs. Clara Hair 5300 Ridgefield Rd. Bethesda, Maryland			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma urinary bladder and acute and chronic polynephritis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from Feb. 2, 19 66, to Feb. 8, 19 66 that (1) (we) last saw the deceased alive on Feb. 8, 19 66, and that death occurred at 3:15 A.M. from causes and on the date stated above.							
22a. SIGNATURE L. A. Jones, M. D.		22b. DATE SIGNED Feb. 9, 1966		22c. PHYSICIAN'S NAME (Type) L. A. Jones, M. D.		22d. ADDRESS U. S. Naval Hospital, Bethesda, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-11-1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR Joseph Gawler & Sons, 5130 Wisconsin Ave., N.W. Washington, D. C.				25a. REC'D BY REGISTRAR DATE FEB 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

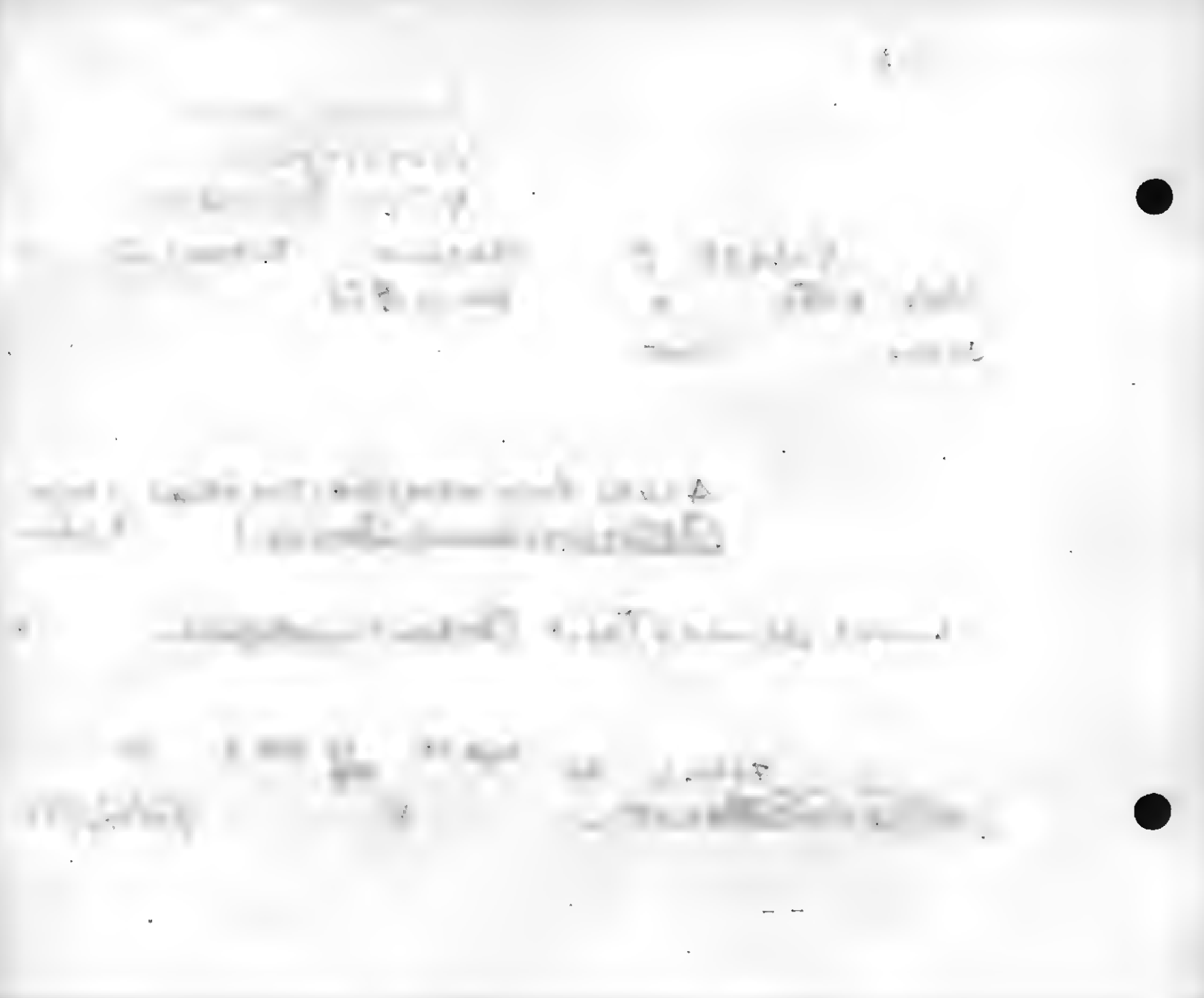
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02514

02475

1. PLACE OF DEATH a. COUNTY <u>Montgomery County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Upper Falls</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Bartholomew Silver Spring N.H.</u>				d. STREET ADDRESS <u>4701- Fulton St. N.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Robert B. Hardison</u>				4. DATE OF DEATH <u>February 2, 1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 16, 1972</u>	
9. AGE (in years last birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Judge</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Court</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kentucky</u>	
13. FATHER'S NAME <u>Robert DeC. Hardison</u>				14. MOTHER'S MAIDEN NAME <u>Mary Ellen Bibb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Mrs. E.C. Gatt (Daughter)</u> Address <u>Sec Item #2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Respiratory Infection, Influenza</u> <u>4500</u> DUE TO (b) <u>Arteriosclerosis, General</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Lower Urinary Tract Obstruction with Calculi</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>8 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Lower Urinary Tract Obstruction with Calculi</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 18, 1958</u> , to <u>Feb 2, 1966</u> that (I) (we) last saw the deceased alive on <u>Febr. 1, 1966</u> and that death occurred at <u>4:45 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Bacon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb. 2, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Bacon M.D.</u>				22d. ADDRESS <u>1150 Conn. Ave. N.W. Wash. D.C.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-4-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland Md.</u>	
24. FUNERAL DIRECTOR <u>Jos. GAWLER &amp; Sons, Inc.</u>				25a. REC'D BY REGISTRAR <u>5130 Wisconsin Ave N.W. Wash. DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

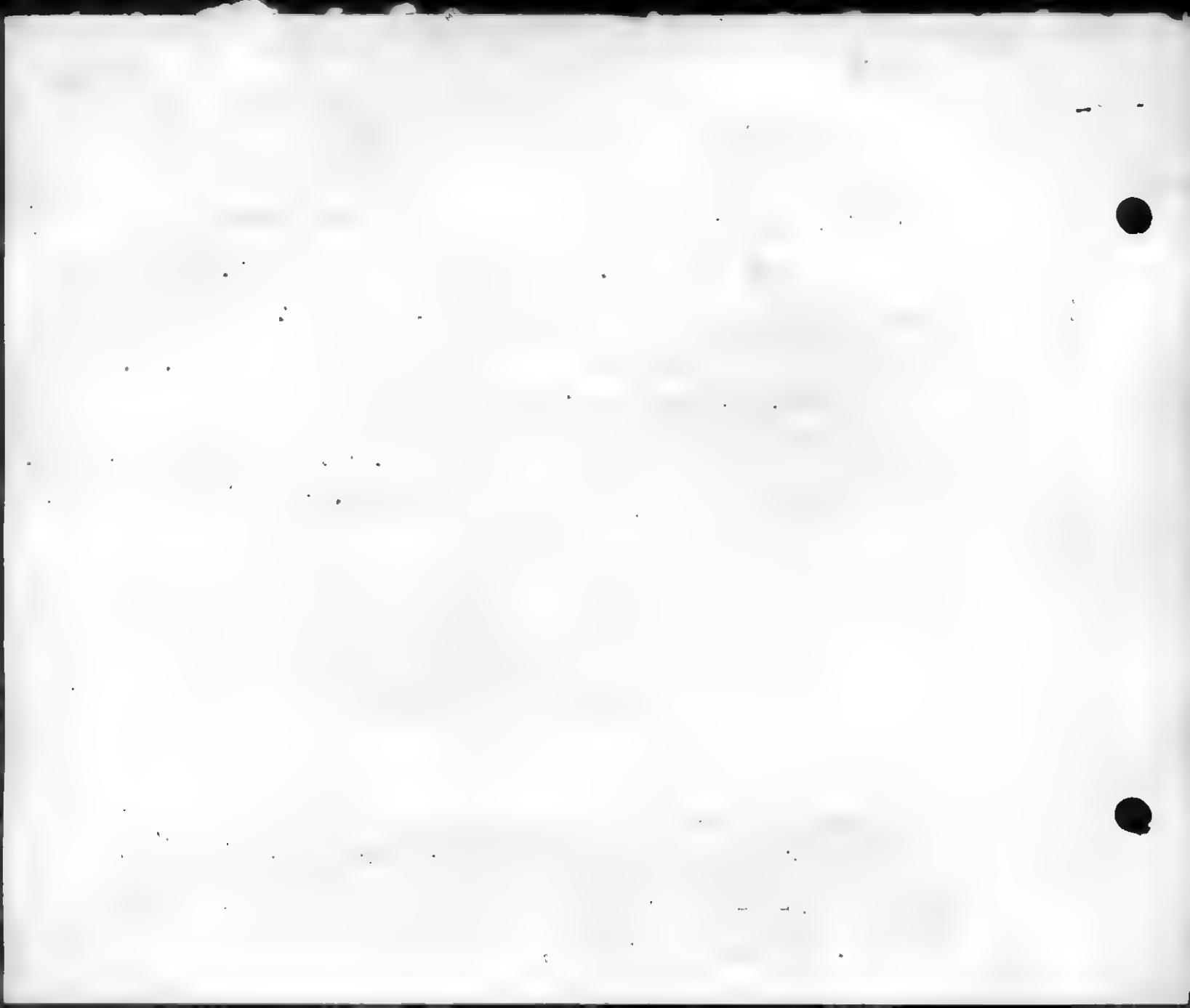


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02515 02476  
**CERTIFICATE OF DEATH**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Bethesda-Silver Spring Nursing Home</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>4504 Maple Avenue</b>			
3. NAME OF DECEASED (Type or print) First <b>MAY</b> Middle <b>V.</b> Last <b>HARRIS</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 24, 1888</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Decorator</b>		11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Charles Townsend Harris</b>				14. MOTHER'S MAIDEN NAME <b>Caroline Bronski</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Sister</b> Address <b>Florence E. Harris Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Adenocarcinoma of Colon with metastasis</b> 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <b>5 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April 1956</b> to <b>Feb 25, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 23 1966</b> , and that death occurred at <b>6:50 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert N. Coale</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Feb 25, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT N. COALE</b>				22d. ADDRESS <b>4429 Bradley Lane, Chevy Chase Ind.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2-25-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town, or county) (State) <b>Suitland, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b>				25a. REC'D BY REGISTRAR <b>MAR 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



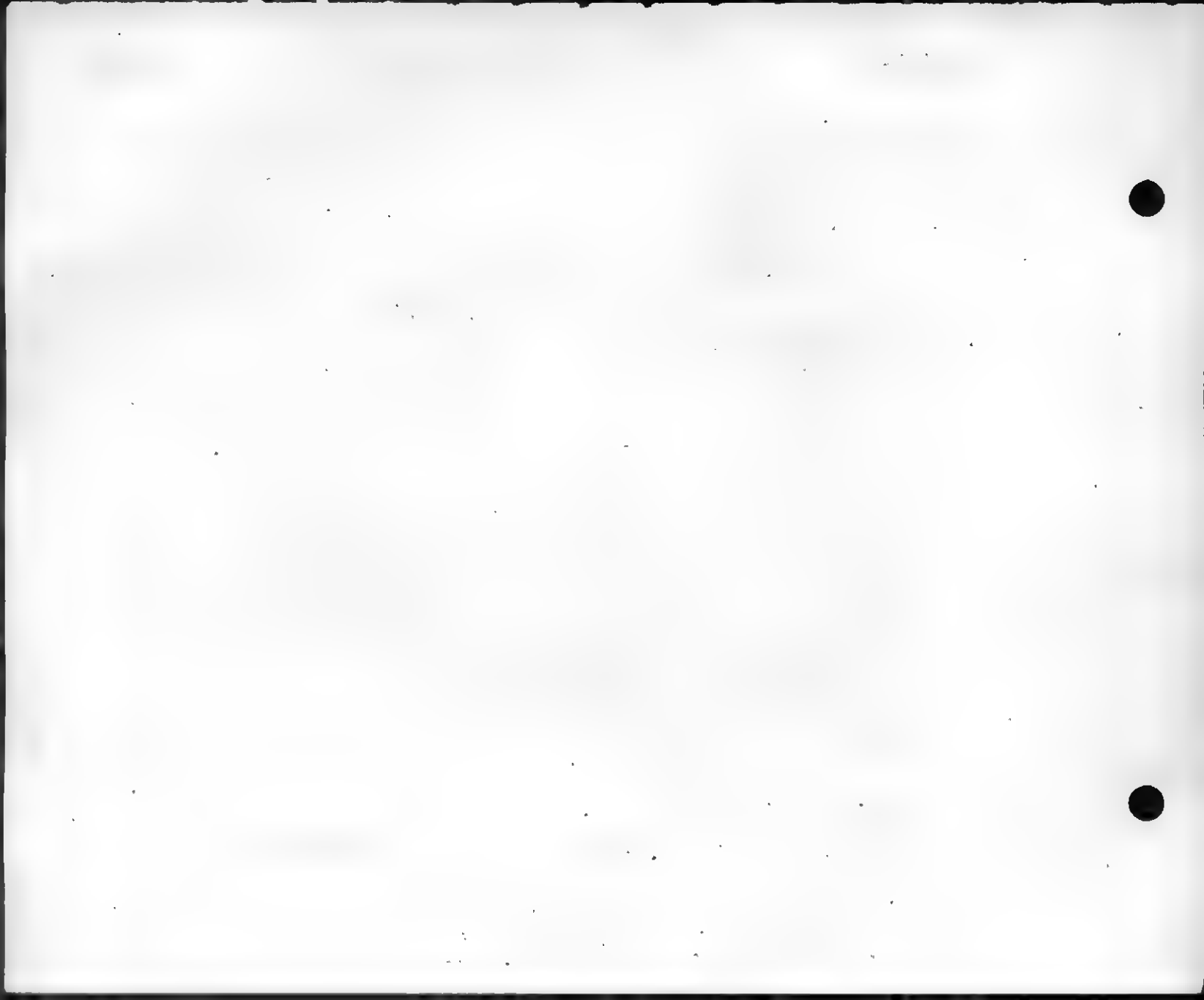


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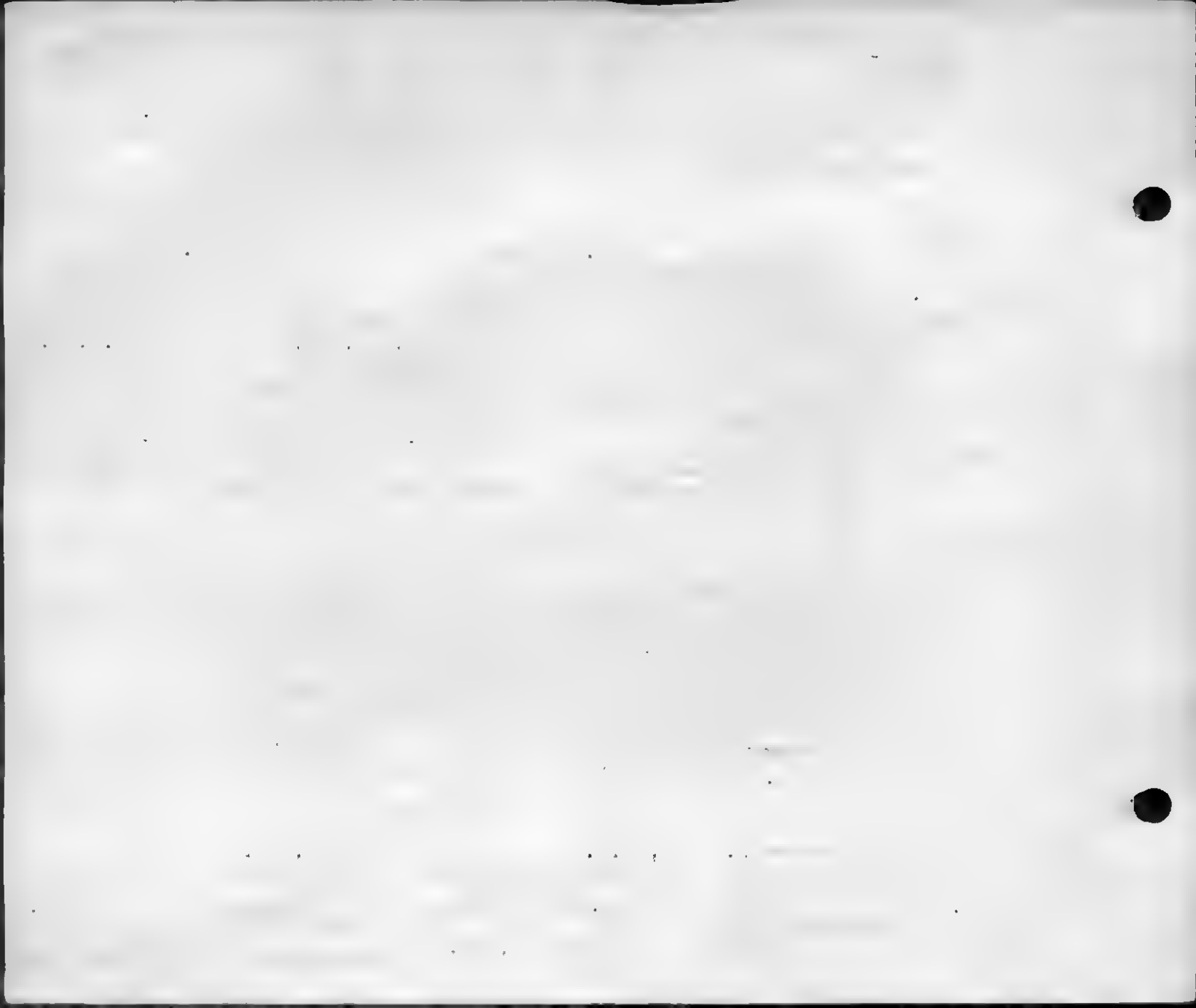
- Cleared with Dr. Keap - Medical Examiner for APP for

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>45min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring, Maryland</u> d. STREET ADDRESS <u>912 Laredo Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>William</u> Middle <u>Franklin</u> Last <u>Hatley</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> Day <u>25</u> Year <u>1966</u>		<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>6/18/21</u>		<b>9. AGE</b> (In years last birthday) <u>44</u> yrs. <u>8</u> Months <u>1</u> Days <u></u> Hours <u></u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Communication Technician</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Government</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Salisbury N.C.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Arlie W. Hatley</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>May Hatley / Cleo Mae Robinson</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>Yes</u> <u>Navy WWI &amp; Korean</u>				<b>16. SOCIAL SECURITY NO.</b> <u>579-10-5169</u>		<b>17. INFORMANT</b> <u>Dorothy Hatley</u> wife, same as dec.	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO <u>Coronary occlusive</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic Cardiovascular Disease</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH <u>1 HOUR</u> <u>2 MONTHS</u>			
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>JULY 1953</u> <b>to</b> <u>FEB 23, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>JAN 28 1966</u> , <b>and that death occurred at</b> <u>10:30 A.M.</u> <b>from the causes and on the date stated above.</b>															
<b>22a. SIGNATURE</b> <u>Robert L. Krichmar</u>				<b>22b. DATE SIGNED</b> <u>February 25 / 1966</u>				<b>22c. PHYSICIAN'S NAME (Type)</b> <u>ROBERT L. KRICHMAR</u>				<b>22d. ADDRESS</b> <u>7733 MASKA AVENUE NW C WASHINGTON DC 20012</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>3-1-66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l Cemetery</u>				<b>23d. LOCATION (City, town or county) (State)</b> <u>Arlington, Virginia</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u>				<b>25a. REC'D BY REGISTRAR</b> <u>Charles Judge</u>				<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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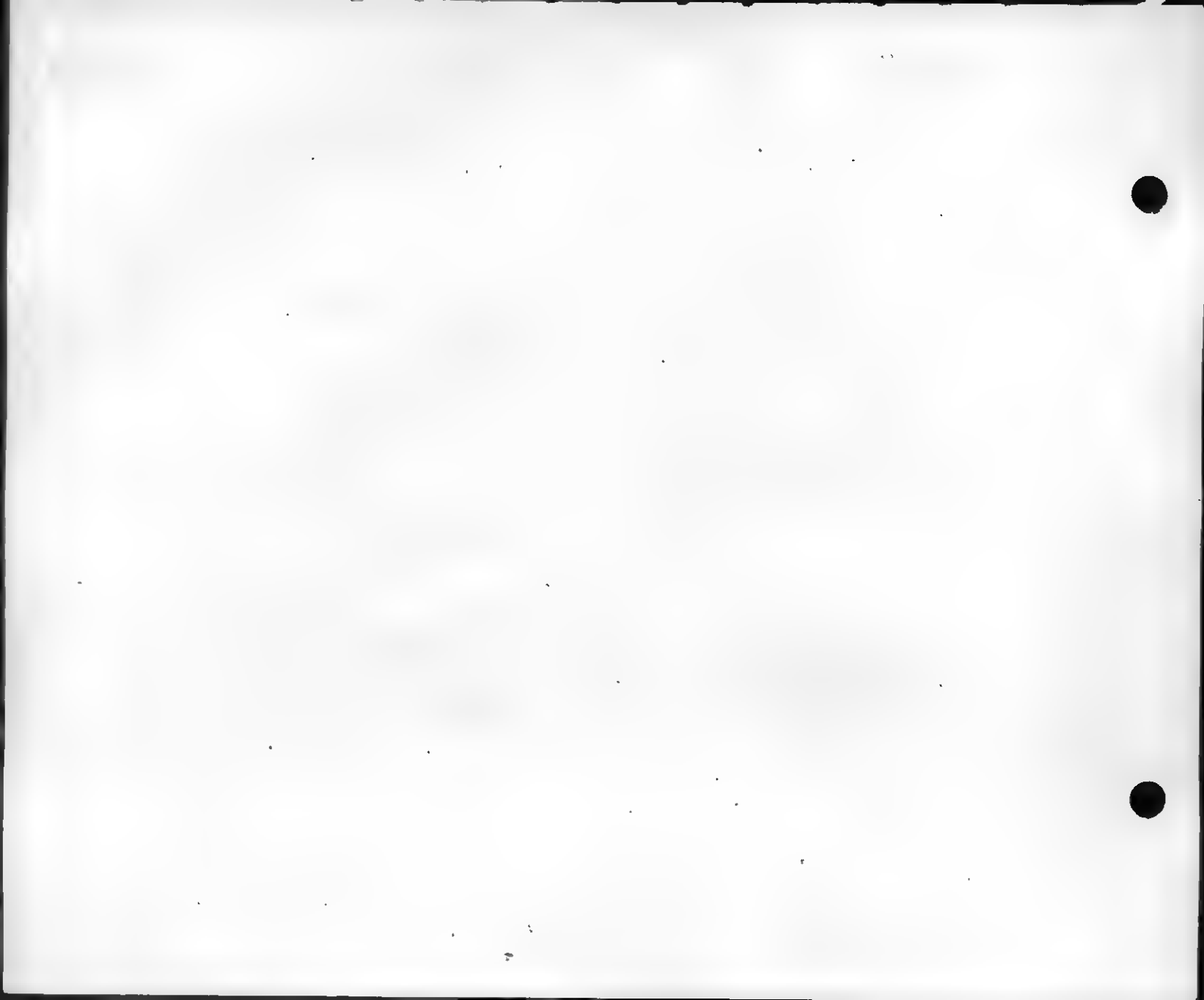
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02517 <span style="float: right;">02478</span>											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montg.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - Rural</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Clarksburg - rural</u>					
c. LENGTH OF STAY IN 1b <u>Life</u>						d. STREET ADDRESS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Gertrude</u> Middle <u>E.</u> Last <u>Hawse</u>						4. DATE OF DEATH Month <u>Feb.</u> Day <u>13</u> Year <u>1966</u>					
5. SEX <u>Fem.</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/6/1874</u>		9. AGE (In years last birthday) <u>92</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	
										IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>						10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montg. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S. A.</u>	
13. FATHER'S NAME <u>Benjamin Burdette</u>						14. MOTHER'S MAIDEN NAME <u>Charity Watkins</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO.		17. INFORMANT <u>Albert B. Hawse</u> Address <u>Bojds Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic - cardiovascular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c)										INTERVAL BETWEEN ONSET AND DEATH <u>15 years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>  </u> <u>  </u> 19 <u>  </u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) ( <del>he</del> <u>she</u> ) attended the deceased from <u>10/1/66</u> to <u>2/1/66</u> , 19 <u>66</u> , that (I) ( <del>we</del> ) last saw the deceased alive on <u>2/1/66</u> and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above											
22a. SIGNATURE <u>James P. Kerr</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3/14/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>James P. Kerr, M.D.</u>						22d. ADDRESS <u>Damascus, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>2/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Methodist</u>			23d. LOCATION (City, town or county) (State) <u>Purdim Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Constance C. Hilton</u>						ADDRESS <u>Barnesville, Md.</u>		25a. REC'D BY REGISTRAR <u>Feb 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02518 CERTIFICATE OF DEATH 02479

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>1</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>	
c. LENGTH OF STAY IN 1b <u>1 day 14 hours</u>		d. STREET ADDRESS <u>8101 Hammond Avenue</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Roland John Hedquist</u>		4. DATE OF DEATH <u>February 22 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1899 May 29 1966</u>
9. AGE (In years last birthday) <u>66 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Mln. <u>66</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant - retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Review + Herald PubCo. Wisconsin</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>United States</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>John Hedquist</u>		14. MOTHER'S MAIDEN NAME <u>Alma</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>Hospital Records</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RT Hemiplegia (Meningeal)</u> DUE TO (b) <u>Acute Atrial Fibrillation</u> DUE TO (c) <u>left Hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2/21/66</u> <u>2/22/66</u> <u>1958</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/24/65</u> to <u>2/22/66</u> , that (I) (we) last saw the deceased alive on <u>2/22/66</u> , and that death occurred at <u>11:45</u> M, from the causes and on the date stated above.		22b. DATE SIGNED <u>2/23/66</u>	
22a. SIGNATURE <u>Howard T. Morse</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>		22d. ADDRESS <u>7030 Carroll Ave Takoma Park Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 26, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>Arthur Walters Washington, D.C.</u>		25. REC'D BY REGISTRAR <u>FEB 25 1966</u>	
25a. ADDRESS <u>254 Carroll St. N.W.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur Walters</u>	



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15M 4-64

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02519

02480

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>MONTGOMERY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MD</b>				c. LENGTH OF STAY IN 1b <b>1 yr. 8 mos.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR SANITARIUM &amp; HOSPITAL</b>				d. STREET ADDRESS <b>5518 Southwick Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Augusta</b> Middle <b>B</b> Last <b>Henkelman</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>1</b> Year <b>1966</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 15, 1878</b>	
9. AGE (in years last birthday) <b>87</b> yrs.		10. FUNDERS 1 YEAR Months <b>7</b> Days <b>16</b> Hours <b></b> Min. <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Teacher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Penna.</b>	
13. FATHER'S NAME <b>Geo. Henkelman</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Stein</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Charles E. Becker</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Parkinson's disease</b> OUE TO (c) <b>Generalized Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a.m.</b> <b>19</b> p.m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10/1/65</b> to <b>2/1/66</b> , that (I) (we) last saw the deceased alive on <b>2/1/66</b> 19, and that death occurred at <b>7:30</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stephen F. Verges</b>				22b. DATE SIGNED <b>2/1/66</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stephen F. Verges</b>				22d. ADDRESS <b>5211 Harmon Lane</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-4-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>				25a. REC'D BY REGISTRAR <b>Bethesda, Maryland</b>			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				DATE <b>FEB 7 1966</b>			





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02520

MARYLAND STATE DEPARTMENT OF HEALTH

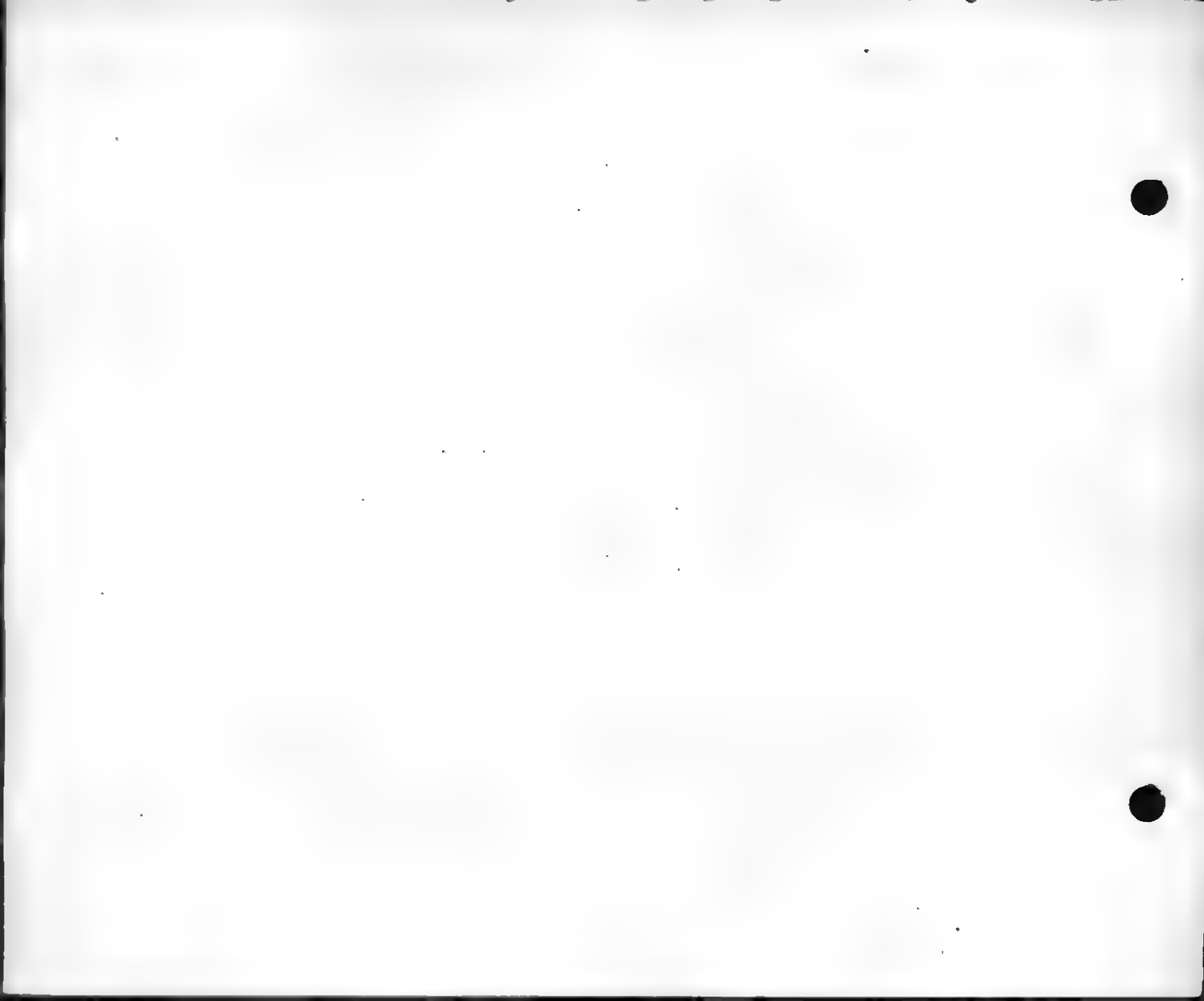
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

02481

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10126 Renfrew Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Lees Hill</u>		4. DATE OF DEATH <u>Feb 9 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-27-75</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		9b. AGE (In years last birthday) <u>90</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Jeweler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rhode Island</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Rhode Island</u>		12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>	
13. FATHER'S NAME <u>James Hill</u>		14. MOTHER'S MAIDEN NAME <u>Agnes Lees</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>	
17. INFORMANT <u>Daughter</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary heart failure A.S.H.D.</u> (b) <u>Grand junction</u> (c) <u>Coronary atherosclerosis + myocardial infarction</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <u>yes</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-6</u> , 19 <u>66</u> , to <u>2-9</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-8</u> , 19 <u>66</u> , and that death occurred at <u>6:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles H. Volotton</u>		22b. DATE SIGNED <u>2/9/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles H. Volotton</u>		22d. ADDRESS <u>1401 Blair Rd NW</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb 14, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkview Highland Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Warwick Rhode Island</u>	
24. FUNERAL DIRECTOR <u>Northwest Walters</u>		25a. REG'D BY REGISTRAR <u>14</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>Feb 14 1966</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

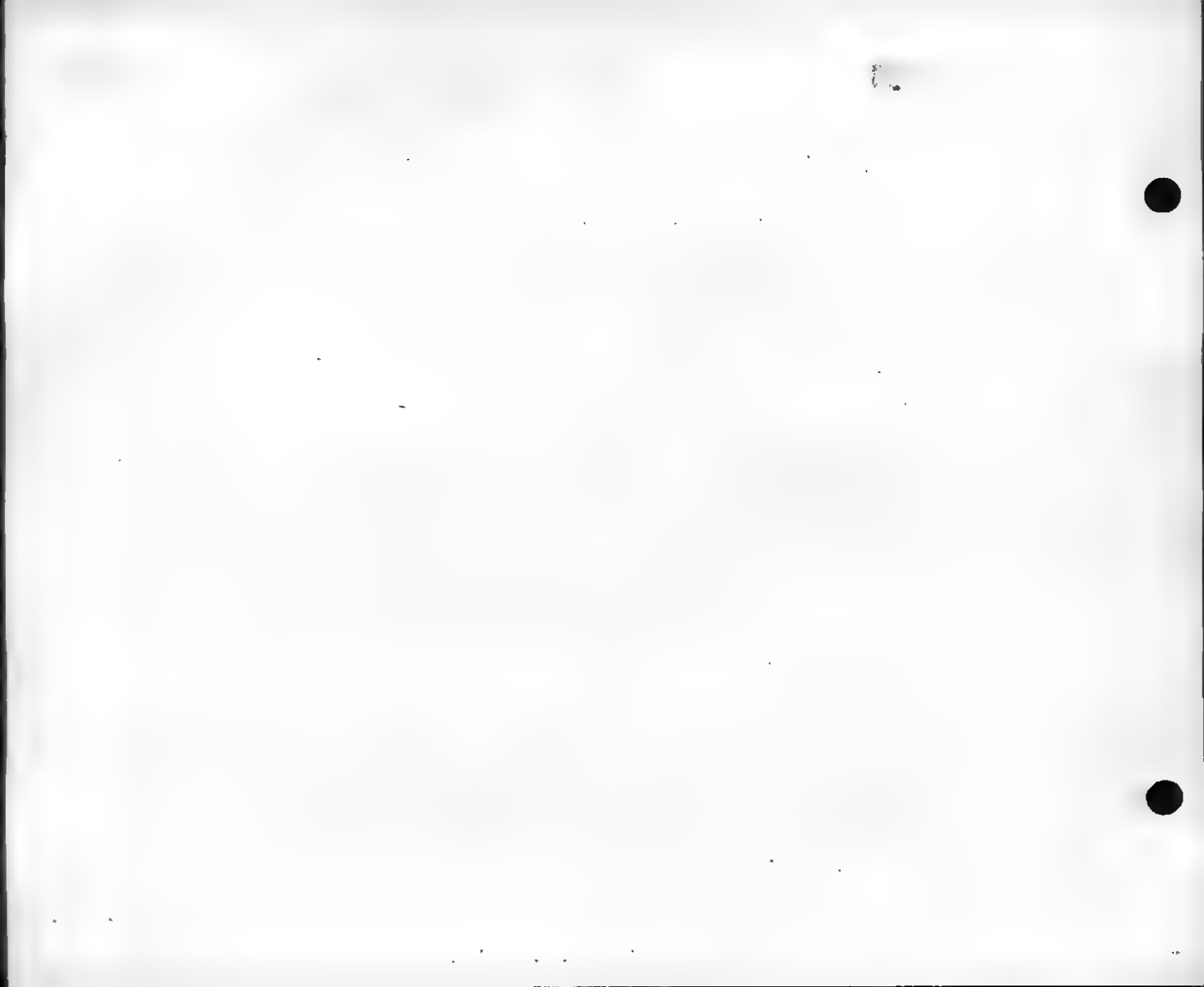
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

02521

02483

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 18 days. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>9417-Lanest Hill Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3. NAME OF DECEASED</b> (Type or print) <u>Constance R. Holmead</u> First Middle Last <b>4. DATE OF DEATH</b> <u>Feb.</u> <u>6</u> <u>1966</u> Month Day Year				<b>5. SEX</b> <u>female</u> <b>6. COLOR OR RACE</b> <u>white</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>11/27/22</u> <b>9. AGE</b> (In years last birthday) <u>43</u> yrs <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Washington, D.C.</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>					
<b>13. FATHER'S NAME</b> <u>John M. King</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Faulkner Kinsolving</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> <b>16. SOCIAL SECURITY NO.</b> <u>- - -</u> <b>17. INFORMANT</b> <u>Franklin Holmead</u> Address <u>13 Home</u>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Large cerebral hemorrhage</u> DUE TO (b) <u>Acute myelogenous leukemia</u> DUE TO (c) <u>2 mo</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last				INTERVAL BETWEEN ONSET AND DEATH					
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Alcohol</u>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED</b> (Enter nature of injury in Part I or Part II of item 18.)				<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	
<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg, etc.)				<b>20f. (City or town) (County) (State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1/19/66</u> , 19 <u>66</u> , <b>1a</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1b</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1c</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1d</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1e</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1f</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1g</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1h</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1i</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1j</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1k</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1l</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1m</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1n</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1o</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1p</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1q</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1r</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1s</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1t</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1u</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1v</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1w</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1x</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1y</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1z</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1aa</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ab</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ac</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ad</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ae</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1af</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ag</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ah</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ai</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1aj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ak</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1al</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1am</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1an</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ao</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ap</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1aq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ar</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1as</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1at</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1au</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1av</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1aw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ax</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ay</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1az</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ba</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1be</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bi</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bo</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1br</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bs</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1by</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1bz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ca</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ce</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ch</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ci</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ck</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1co</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cs</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ct</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1cz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1da</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1db</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1de</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1df</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1di</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1do</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ds</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1du</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1dz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ea</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ec</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ed</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ee</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ef</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ei</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ej</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ek</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1el</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1em</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1en</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eo</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ep</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1er</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1es</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1et</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1eu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ev</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ew</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ex</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ey</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ez</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fa</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fe</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ff</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fi</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fo</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fs</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ft</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1fz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ga</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ge</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gi</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1go</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gs</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1gz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ha</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1he</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hi</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ho</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hs</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ht</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1hz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ia</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ib</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ic</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1id</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ie</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1if</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ig</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ih</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ii</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ij</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ik</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1il</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1im</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1in</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1io</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ip</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ir</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1is</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1it</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ix</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1iz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ja</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1je</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ji</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jo</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1js</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ju</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jy</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1jz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ka</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kd</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ke</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ki</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kl</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1km</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kn</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ko</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ks</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ku</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ky</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1kz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1la</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ld</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1le</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1li</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ll</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lm</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ln</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lo</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lp</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lq</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lr</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ls</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lt</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lu</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lv</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lw</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lx</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ly</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1lz</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ma</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mb</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mc</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1md</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1me</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mf</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mg</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mh</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mi</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mj</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1mk</b> <u>2/6/66</u> , 19 <u>66</u> , <b>1ml</b> <u>2/6/66</u>									



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

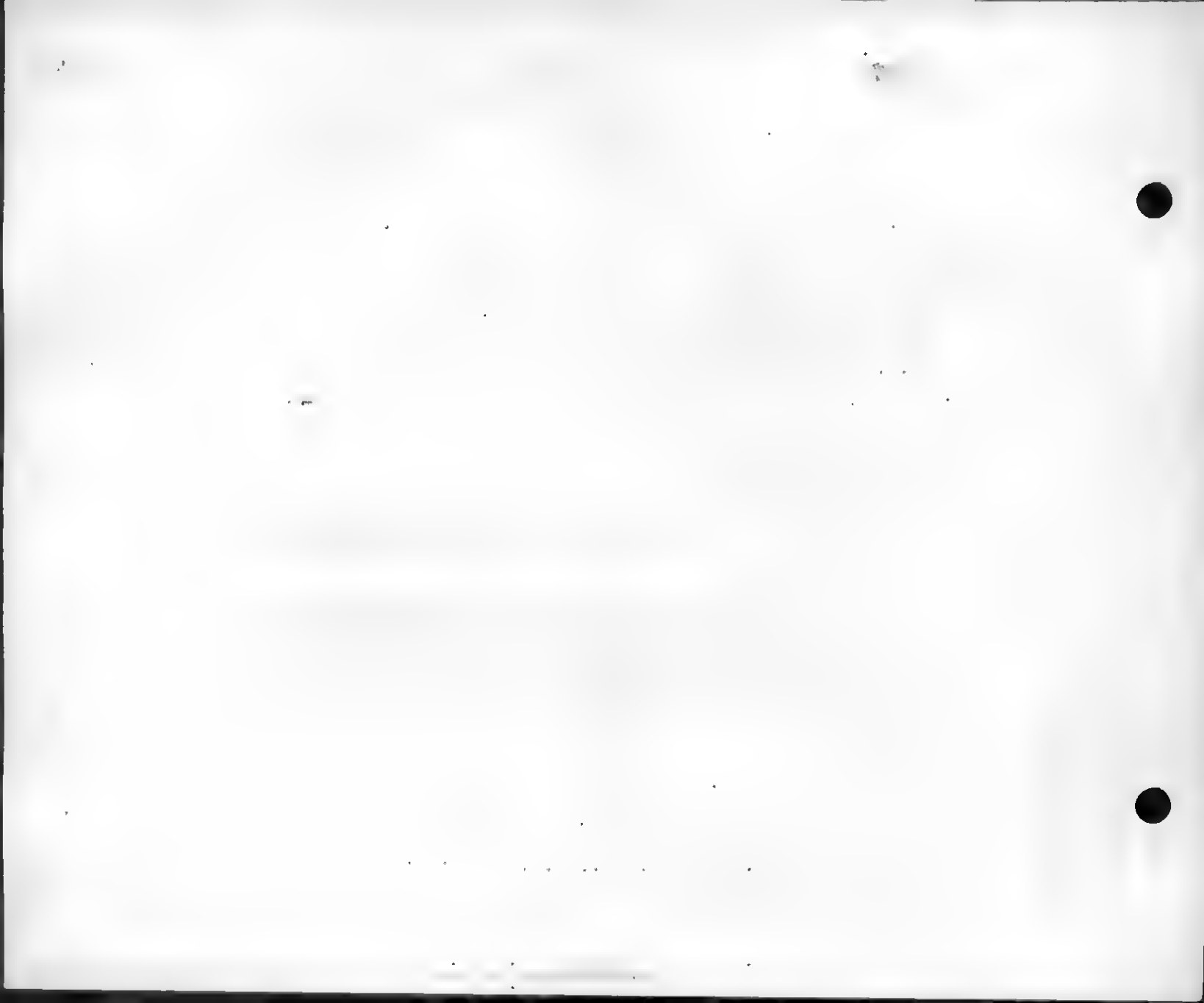
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

02522

02484

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN 1b <b>10 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>		e. STREET ADDRESS <b>9707 Bellevue Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Charles Adam HORN</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>8</b> Year <b>19 66</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 27, 1892</b>
9. AGE (in years last birthday) <b>73</b> yrs		10. F UNDER 1 YEAR Months <b></b> Days <b></b> IF UNDER 24 HRS Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Air Force -</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Liberty, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Adam Horn</b>		14. MOTHER'S MAIDEN NAME <b>Amelia Kregur</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <b>Yes</b>		16. SOCIAL SECURITY NO <b>579 52 7426</b>	
17. INFORMANT <b>Mrs. Marguerite A. Horn</b>		18. ADDRESS <b>Bethesda, Md. 9707 Bellevue Drive</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> DUE TO (b) <b>Thrombosis, left middle cerebral artery</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b></b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (it) (this hospital) attended the deceased from <b>Jan. 30</b> , 19 <b>66</b> , to <b>Feb. 8</b> , 19 <b>66</b> , that (it) (we) lost <b>saw</b> the deceased alive on <b>Feb. 8</b> , 19 <b>66</b> , and that death occurred at <b>1:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>William L. Brannon, Jr.</b> M.D.		22b. DATE SIGNED <b>Feb. 9, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>William L. Brannon, Jr., M.D.</b>		22d. ADDRESS <b>U. S. Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-14-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons, 5130 Wisconsin Ave., N.W.</b>		25a. REC'D BY REGISTRAR <b>DATE FEB 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

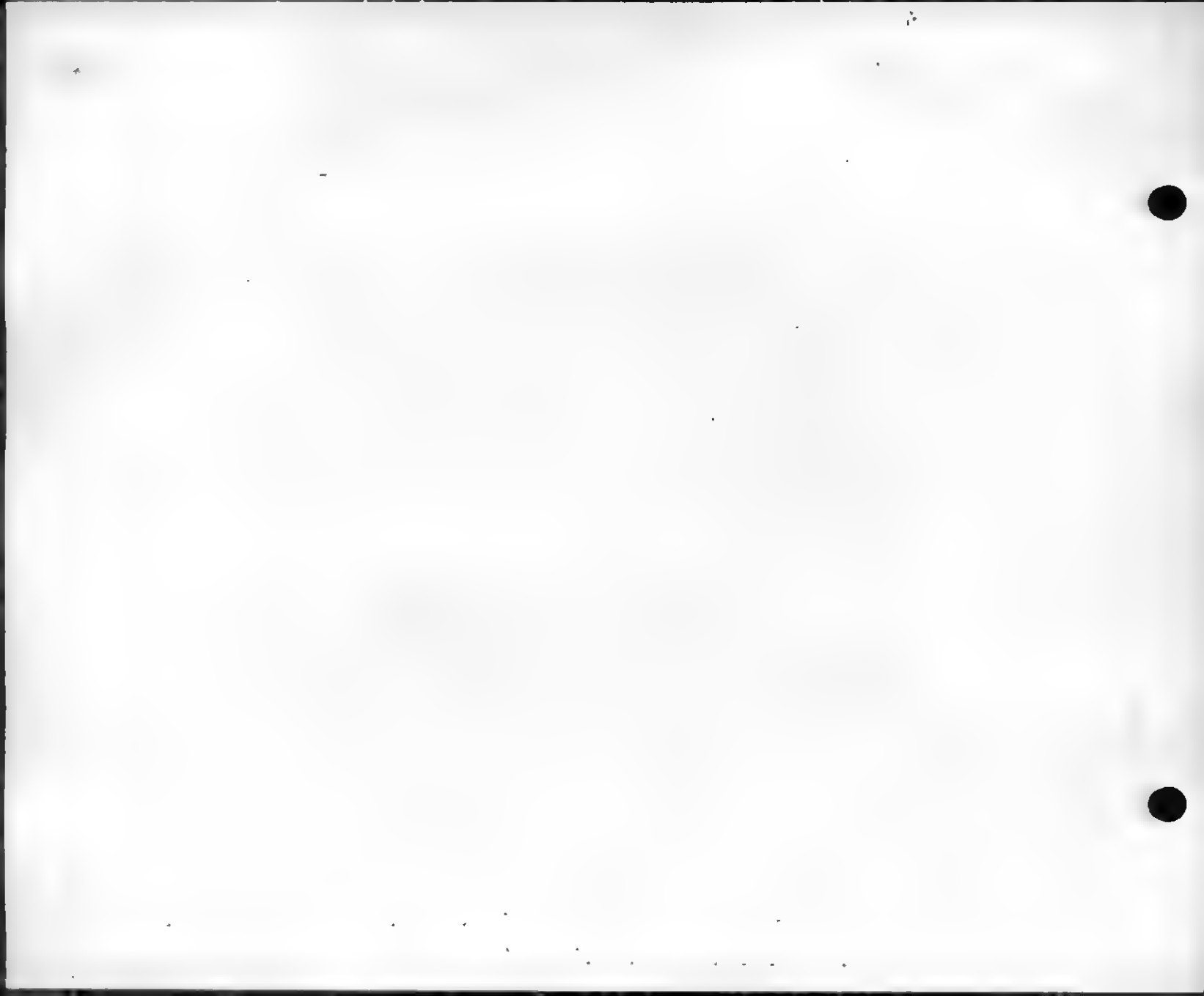
02523

02485

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u>	
c. LENGTH OF STAY IN 1b <u>6 days</u>		d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>9707 BELLEVUE DRIVE</u>	
3 NAME OF DECEASED (Type or print) First <u>JACQUELINE</u> Middle <u>R</u> Last <u>HORN</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>15</u> Year <u>1966</u>	
5 SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 7-1924</u>
9. AGE (In years last birthday) <u>41</u>		F UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11 BIRTHPLACE (County & State or foreign country) <u>SAN ANTONIO TEXAS</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>COL. CHARLES ADAM HORN</u>		14 MOTHER'S MAIDEN NAME <u>MARGUERITE REARDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>291-28-6793</u>	
17 INFORMANT <u>MARGUERITE HORN (mother)</u>		Address <u>9707 BELLEVUE DRIVE</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, breast, with widespread metastases.</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> to <u>Feb 15</u> , 19 <u>66</u> , that (I) <u>(we)</u> lost saw the deceased alive on <u>Feb 15</u> , 19 <u>66</u> , and that death occurred at <u>11 P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Marvin Wadler</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>MARVIN WADLER</u>		22d. ADDRESS <u>8218 Wisconsin Av. Beth, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-18-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler &amp; Sons, Inc.</u> <u>5130 Wisc. Ave. N.E. Wash. DC.</u>		25a REC'D BY REGISTRAR <u>DATE FEB 21 1966</u>	
		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any case within 72 hours after death.





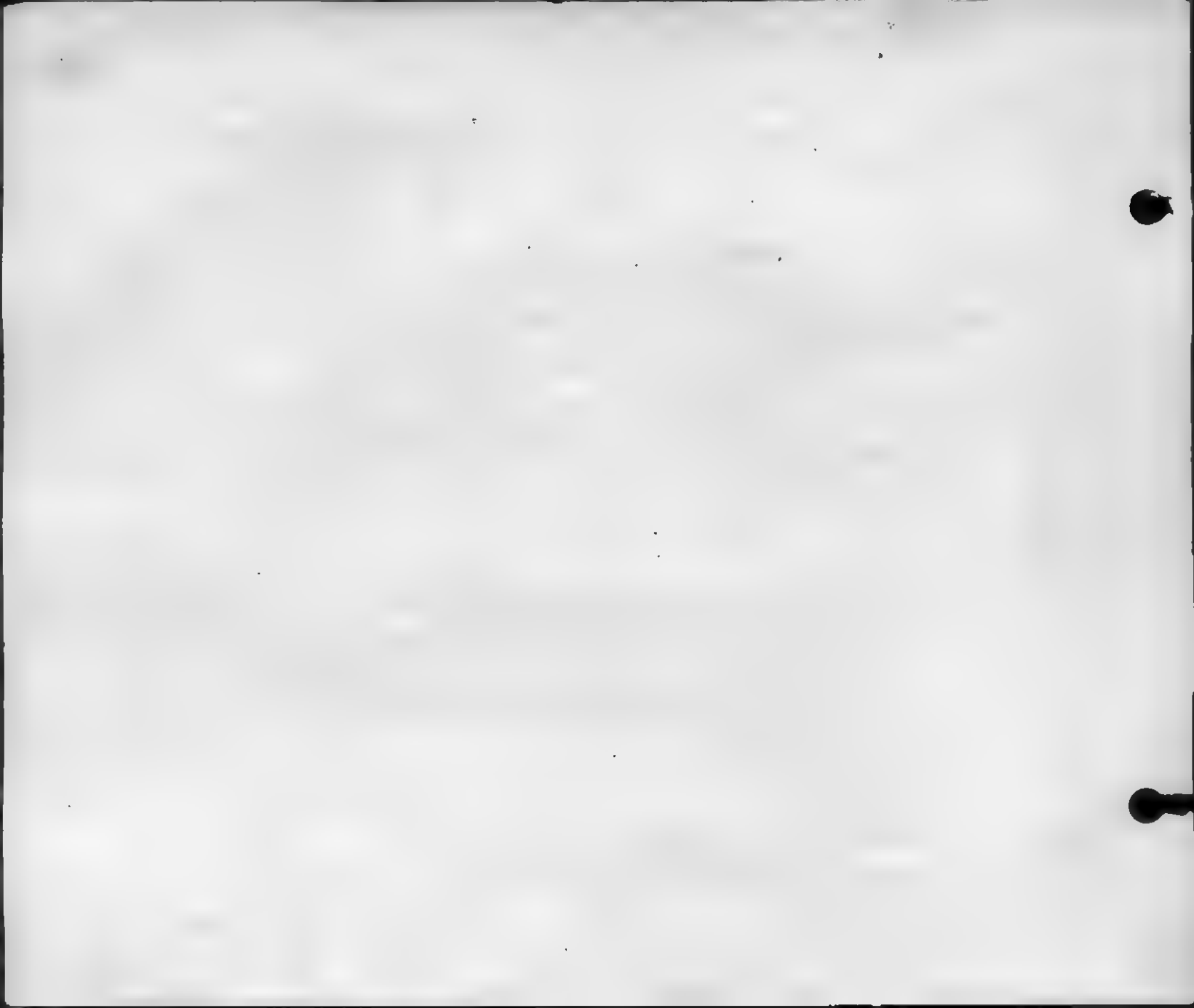
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

025224  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
It is to be filed in File # 374 278  
**CERTIFICATE OF DEATH**

02486

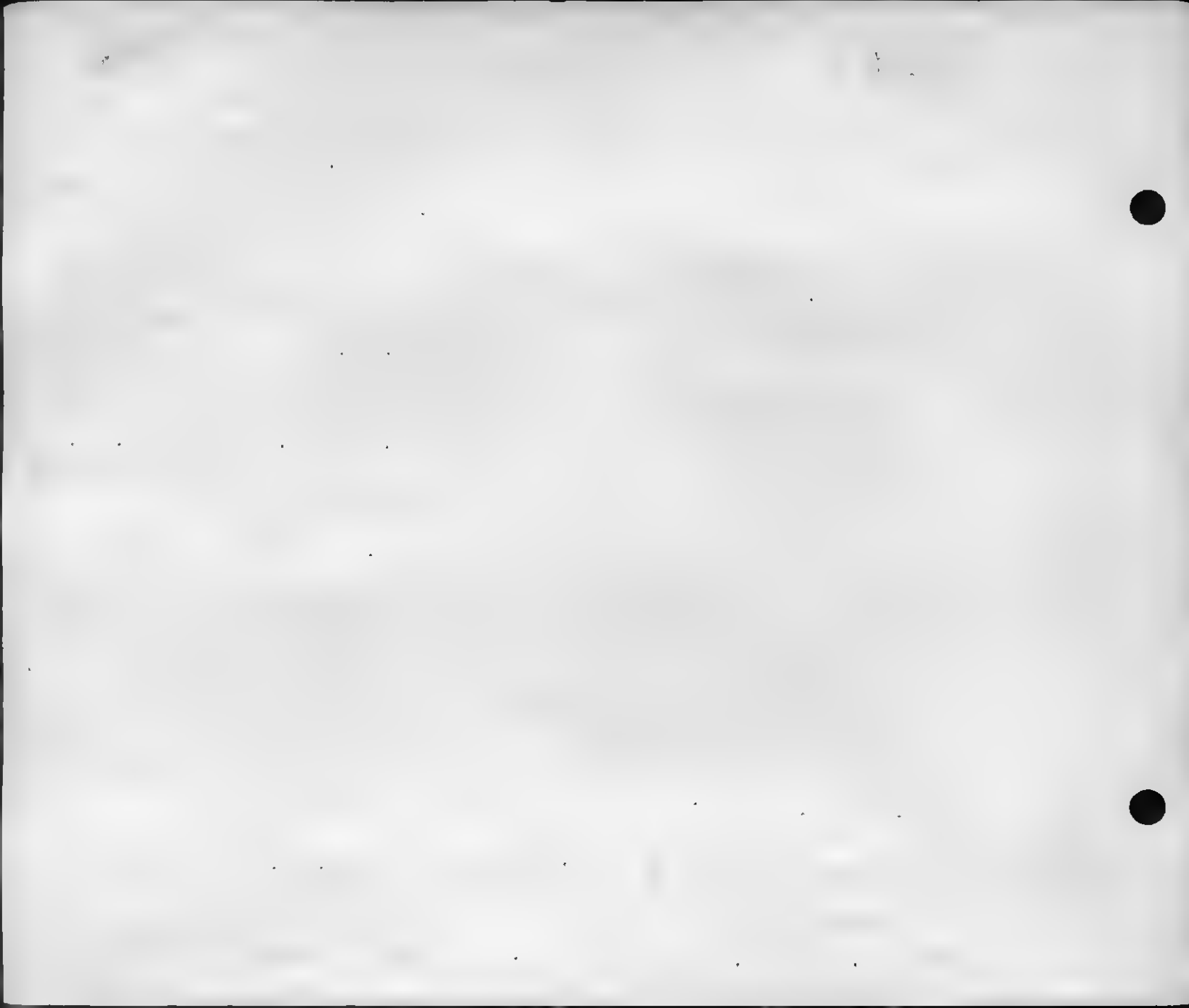
1. PLACE OF DEATH a. COUNTY <i>Montgomery</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>to Koma Park</i>		c. LENGTH OF STAY IN 1b <i>5 hrs</i>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Beltsville</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>11907 Holly tree Court</i>		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Hettie Jane Horsmon</i>		4. DATE OF DEATH Month <i>2</i> - Day <i>14</i> Year <i>1966</i>		5. SEX <i>female</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>6-9-1916</i>		9. AGE (In years last birthday) <i>49 yrs.</i>		10. IF UNDER 1 YEAR Months <i>49</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		12. KIND OF BUSINESS OR INDUSTRY		13. BIRTHPLACE (County & State, or foreign country) <i>D.C.</i>		14. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		15. FATHER'S NAME <i>Jerry E. Thomas</i>		16. MOTHER'S MAIDEN NAME <i>Emma Boswell</i>		17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>NONE</i>		18. SOCIAL SECURITY NO. <i>579-28-2696</i>	
19. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>156.2</i> DUE TO <i>Hepatic coma</i>		Conditions, if any, which gave rise to immediate cause (b) <i>metastatic Ca. of liver</i>		causing the underlying cause last. (c) <i>Possible Ca breast (vs Gallbladder)</i>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>diabetes mellitus</i>		INTERVAL BETWEEN ONSET AND DEATH <i>12 hrs.</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		approx 14.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 5</i> 1965, to <i>Feb 14</i> 1966, that (I) (we) last saw the deceased alive on <i>Feb 13</i> 1966, and that death occurred at <i>3:30 PM</i> , from the causes and on the date stated above.															
22a. SIGNATURE <i>John R Spencer</i>		22b. DATE SIGNED <i>2-14-66</i>		22c. PHYSICIAN'S NAME (Type) <i>John R Spencer</i>		22d. ADDRESS <i>BURTONSVILLE, MD</i>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. (City or town) (County) (State)		22g. (City or town) (County) (State)		22h. (City or town) (County) (State)	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <i>2/16/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St. Ignace Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Beltsville, Md.</i>		23e. (City or town) (County) (State)		23f. (City or town) (County) (State)		23g. (City or town) (County) (State)		23h. (City or town) (County) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Frank G. Goshals &amp; Sons</i>		24b. ADDRESS <i>1729 Patuxent</i>		24c. (City or town) (County) (State) <i>Beltsville, Md.</i>		24d. (City or town) (County) (State)		24e. (City or town) (County) (State)		24f. (City or town) (County) (State)		24g. (City or town) (County) (State)		24h. (City or town) (County) (State)	



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VR A15 (4)  
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
Item #1d Film #0373 2/11/66											
1. PLACE OF DEATH a. COUNTY		Montg		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Res dance before admision) a. STATE		Maryland		b. COUNTY Montg,	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Gaithersburg		c. LENGTH OF STAY IN 15 51Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Gaithersburg.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		440 E. Diamond Ave.		d. STREET ADDRESS		420 E. Diamond Ave.					
3. NAME OF DECEASED (Type or print)		First Roberta		Middle Columbia		Last Jacobs		4. DATE OF DEATH		Month Day Year Feb 2nd 1966 19	
5 SEX		Female		6. COLOR OR RACE		White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH	
										9. AGE (in years last birthday) 80 yrs.	
										IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		House Wife		10b. KIND OF BUSINESS OR INDUSTRY		##		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
								Woodfield. Md.		U S A	
13. FATHER'S NAME		Singleton King		14. MOTHER'S MAIDEN NAME		Mary Burdette					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
						James W. Jacobs.		Gaithersburg. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Carcinoma Pancreas		INTERVAL BETWEEN ONSET AND DEATH		157X		DUE TO	
		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)							
				(c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Feb 1965, to Feb 2 1966, that (I) (we) last saw the deceased alive on Jan 30 1966, and that death occurred at 11 A.M. from the causes and on the date stated above.											
22a. SIGNATURE		Jack Schumacher		M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		2-3-66	
22c. PHYSICIAN'S NAME (Type)		Jack Schumacher M. D.		22d. ADDRESS		Gaithersburg. Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		Burial		23b. DATE THEREOF		2-5-66		23c. NAME OF CEMETERY OR CREMATORY		Forest Oak	
								23d. LOCATION (City, town or county) (State)		Gaithersburg Md.	
24 FUNERAL DIRECTOR'S SIGNATURE		Ernest C. Gartner		ADDRESS		Gaithersburg. Md.		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
								FEB 7 1966		Charles Judge	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

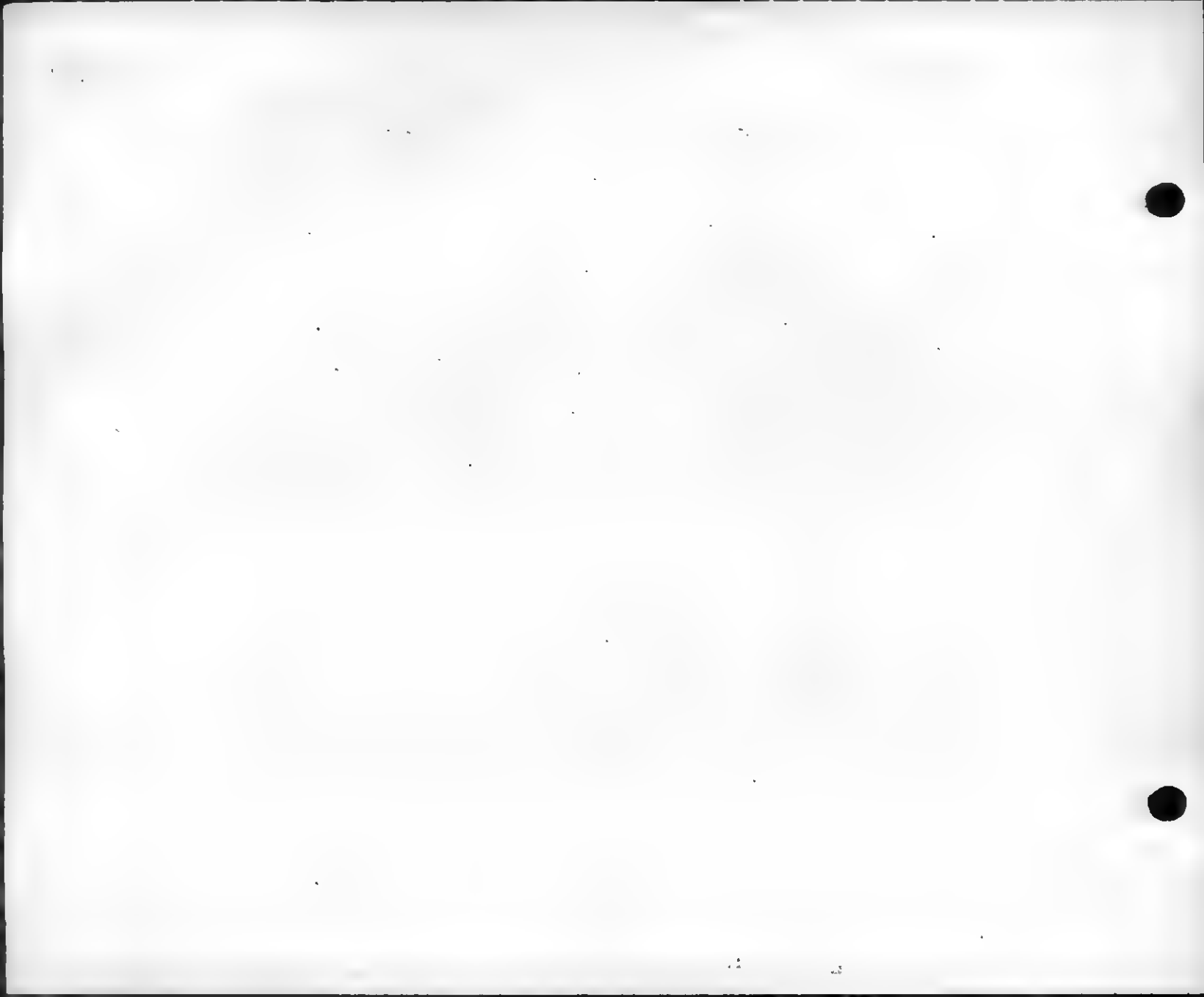
02526

02488

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>7901- River Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Harry</u> Middle <u>Ellis</u> Last <u>Johnson</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 14, 1898</u>
9. AGE (In years last birthday) <u>67</u> yrs		10. UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	11. UNDER 24 HRS Hours <u>  </u> Min <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>farming</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Burridge Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Adams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO <u>577-26-0050</u>	
17. INFORMANT <u>Lebraska F.E. Johnson</u>		Address <u>  </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>ARTERIAL Hypertension</u> DUE TO (c) <u>ARTERIOSCLEROSIS</u>		INTERVAL BETWEEN ONSET AND DEATH <u>15 Hours</u> <u>20 Years</u> <u>20 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC Renal FAILURE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>FEB 22</u> , 19 <u>66</u> , to <u>FEB 28</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>FEB 27</u> , 19 <u>66</u> , and that death occurred at <u>5:47</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Gordon S. Rosenberger M.D.</u>		22b. DATE SIGNED <u>Feb 28/1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gordon S. Rosenberger</u>		22d. ADDRESS <u>310 West Mtg. Ave. Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>3/3/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City or town) (County) (State) <u>Rockville Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert C. Snowden</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. DATE <u>MAR 3 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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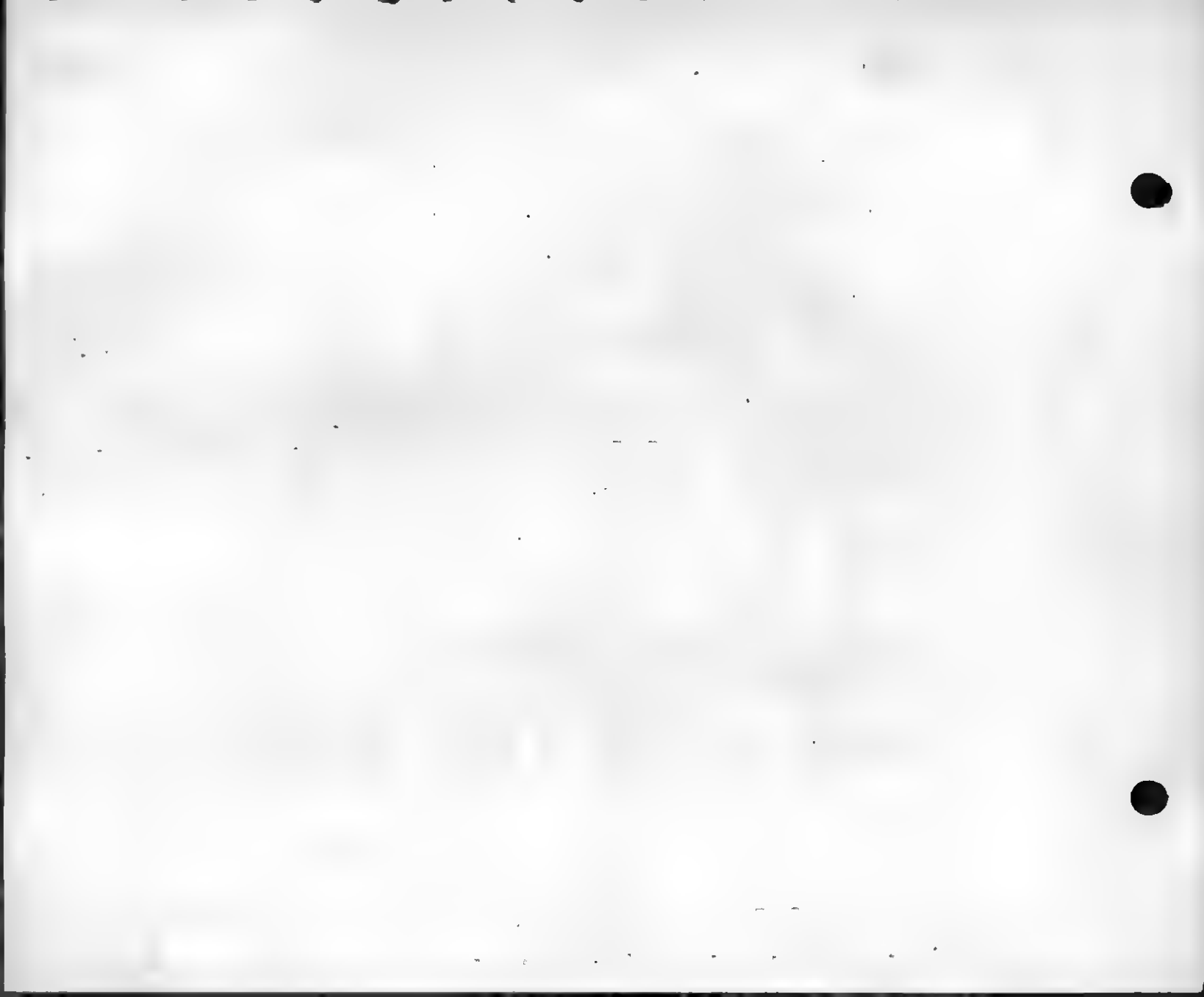


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then page 4 should be removed, removed, or removed, and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02527 CERTIFICATE OF DEATH 02490

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium and Hospital</u>		d. STREET ADDRESS <u>8104 Carroll Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Harold Randolph Keefe</u>		4. DATE OF DEATH <u>February 10 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 30, 1894</u>
9. AGE (In years last birthday) <u>71</u> yrs.		10. FUNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac Steele</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>McClellan Keefe</u>		14. MOTHER'S MAIDEN NAME <u>Florence Shirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>Army WWI</u>		16. SOCIAL SECURITY NO. <u>215-09-8767</u>	
17. INFORMANT <u>Goldie C. Keefe</u> Address <u>8104 Carroll Lane Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS, MASSIVE.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>ARTERIOSCLEROTIC VASCULAR DISEASE.</u> DUE TO (c) <u>? YEARS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>Feb. 7, 1966</u> , to <u>Feb 9, 1966</u> , that (2) (we) last saw the deceased alive on <u>Feb 9 1966</u> , and that death occurred at <u>2:25</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>James K Coleman MD.</u>		22b. DATE SIGNED <u>Feb 10, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES K COLEMAN</u>		22d. ADDRESS <u>6241 COLUMBIA BLVD. SILVER SPRING MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-14-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>W. Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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M

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02528

02491

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>15 years</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>5817 Kingswood Road</b>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>5817 Kingswood Road</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Stanley Kenneth Kellogg</b> First Middle Last 4. DATE OF DEATH <b>Feb. 20, 1966</b> Month Day Year		5. SEX <b>Male</b> 6. COLOR OR RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <b>Sept. 23, 1893</b> 9. AGE (In years last birthday) <b>72</b> yrs. 10. IF UNDER 1 YEAR Months <b>4</b> Days <b>27</b> 11. IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed (Invalid)</b> 10b. KIND OF BUSINESS OR INDUSTRY <b></b> 11. BIRTHPLACE (County & State, or foreign country) <b>New York</b> 12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>		13. FATHER'S NAME <b>Frank Kellogg</b> 14. MOTHER'S MAIDEN NAME <b>Susan Fisher</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. <b>Unknown</b> 17. INFORMANT <b>Wife Anna M. Kellogg</b> Address <b>Same as Item 2.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> <b>4200</b> DUE TO (b) <b>Arteriosclerotic heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) <b></b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary emphysema &amp; fibrosis</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a.m. <b></b> p.m. <b></b> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b></b> 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>April, 1962</b> to <b>20 Feb. 1966</b> that (I) (we) last saw the deceased alive on <b>Jan 20, 1966</b> and that death occurred at <b>1:45 PM</b> , from the causes and on the date stated above.	
22a. SIGNATURE <b>George Sharpe</b> 22b. DATE SIGNED <b>2-21-66</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. PHYSICIAN'S NAME (Type) <b>GEORGE SHARPE</b> 22d. ADDRESS <b>10511 Summit Ave., Kensington, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 2-21-66</b> 23b. DATE THEREOF <b>2-21-66</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Marion Cemetery</b> 23d. LOCATION (City, town or county) (State) <b>Marion, New York</b>		24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> ADDRESS <b>Bethesda, Maryland</b> 25a. REC'D BY REGISTRAR <b>FEB 24 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02529

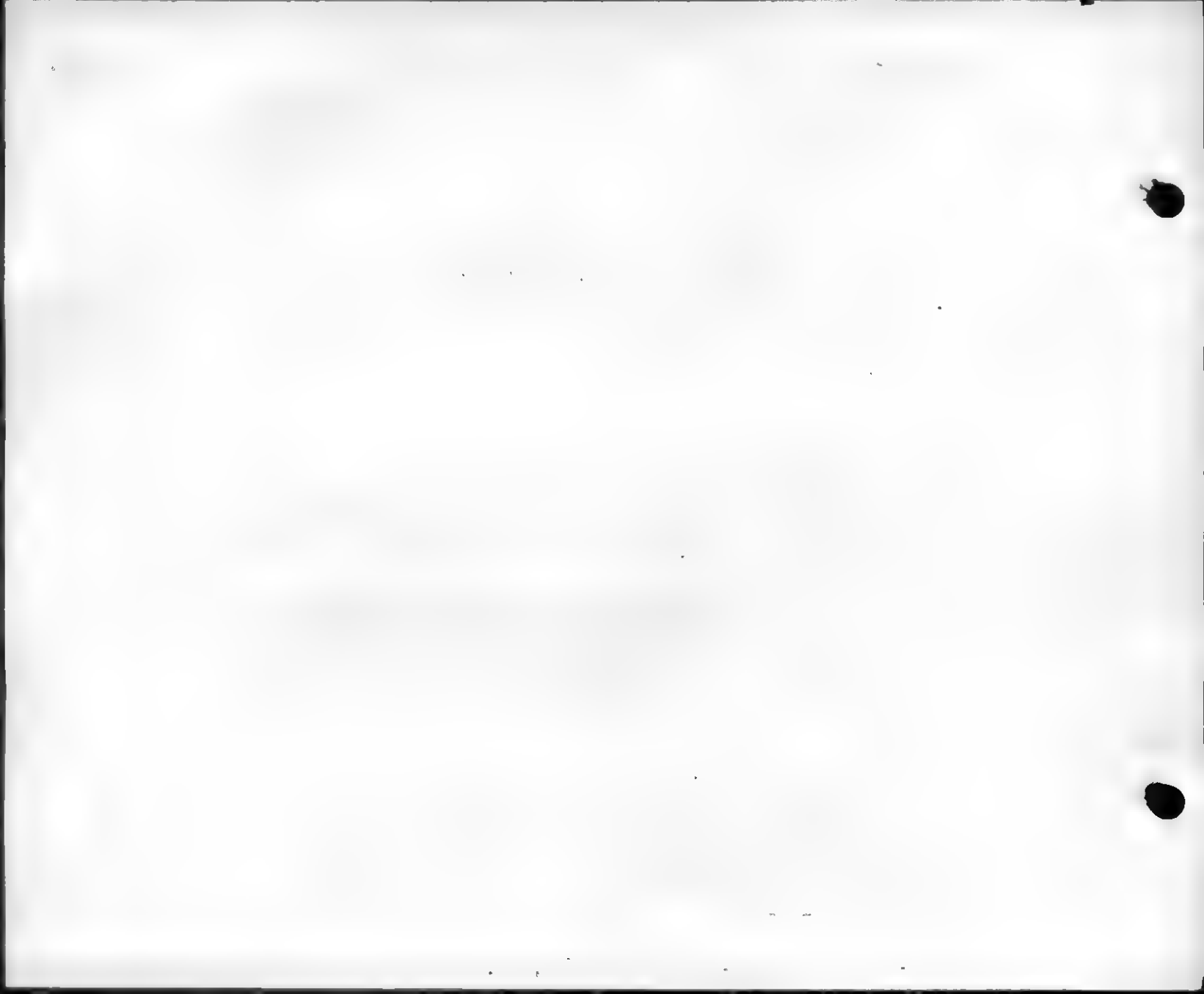
## CERTIFICATE OF DEATH

02492

<b>1 PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN TB <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>				<b>2 USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>SILVER SPRING</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>2407 SEMINARY RD</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>3 NAME OF DECEASED</b> (Type or print) First <u>ELLA</u> Middle <u>HENNESSY</u> Last <u>KOHN</u>				<b>4 DATE OF DEATH</b> Month <u>FEB</u> Day <u>7</u> Year <u>1966</u>					
<b>5 SEX</b> <u>F</u>		<b>6 COLOR OR RACE</b> <u>W</u>		<b>7 MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8 DATE OF BIRTH</b> <u>6-4-84</u>		<b>9 AGE</b> (In years last birthday) <u>81</u> F UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min	
<b>10a USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11 BIRTHPLACE</b> (County & State, or foreign country) <u>Germany, Prussia</u>		<b>12 CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13 FATHER'S NAME</b> <u>Michael J. Hennessy</u>				<b>14 MOTHER'S MAIDEN NAME</b> <u>Ellen Clancy</u>					
<b>15 WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>				<b>16 SOCIAL SECURITY NO.</b> <u>Yes</u>		<b>17 INFORMANT</b> <u>Howard M. Kohn</u> Address <u>...</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>Years</u>								INTERVAL BETWEEN ONSET AND DEATH	
<b>PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>19</u> p.m.				<b>20d INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f (City or town) (County) (State)</b>	
<b>21 I certify</b> that (I) (this hospital) attended the deceased from <u>2/1</u> , 19 <u>66</u> , to <u>2/7</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/7</u> , 19 <u>66</u> , and that death occurred at <u>3 AM</u> , from causes on and the date stated above									
<b>22a. SIGNATURE</b> <u>Richard H. Pollen</u>						<b>22b. DATE SIGNED</b> <u>2/7/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>RICHARD H. POLLEN</u>	
<b>22d. ADDRESS</b> <u>10511 SUMMIT AVE, KENSINGTON</u>									
<b>23a BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b DATE THEREOF</b> <u>2-10-66</u>		<b>23c NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l Cemetery</u>		<b>23d LOCATION (City or Town) (County) (State)</b> <u>Arlington, Virginia</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>						<b>25a. REC'D BY REGISTRAR</b> <u>DATE FEB 10 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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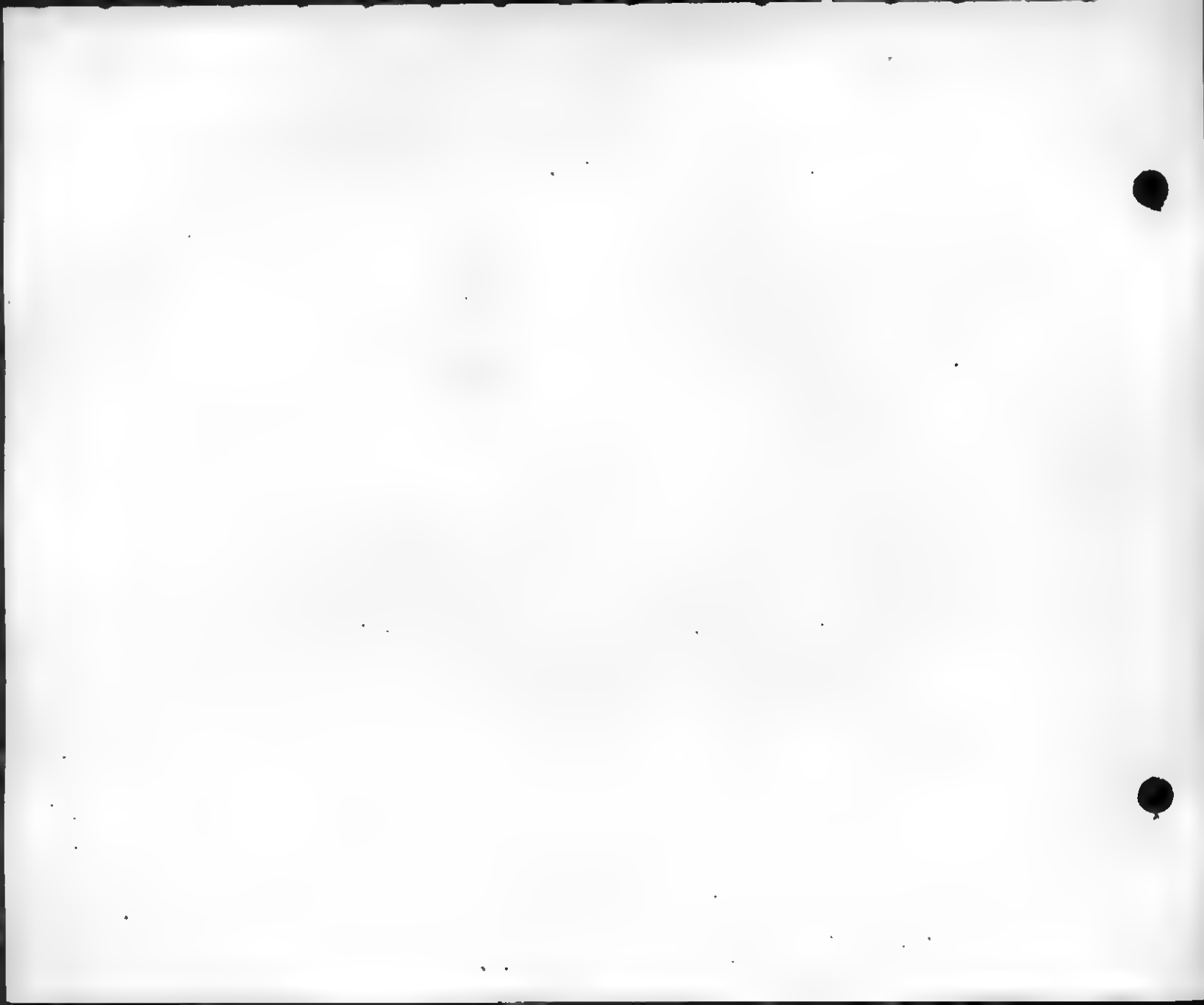
VR A15 (4)  
20M 1/65

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02530 CERTIFICATE OF DEATH 02494

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>5 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitorium + Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Washington DC</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington DC</u> d. STREET ADDRESS <u>5711 9th St. NW</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ludwig Frederick Krafthofer</u> First Middle Last				4. DATE OF DEATH <u>Feb 2 1966</u> Month Day Year			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6-6-92</u> 73 yrs.	
9. AGE (in years last birthday) <u>73</u>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Krafthofer's Market</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Amer</u>							
13. FATHER'S NAME <u>Ludwig</u>				14. MOTHER'S MAIDEN NAME <u>Christine Schneider</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>578-46-8655</u>		17. INFORMANT <u>med. records</u> Address <u>W. S. H.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA, terminal</u> DUE TO (b) <u>CARCINOMA, throat</u> DUE TO (c) <u>PARKINSONS DISEASE, LEFT SIDE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PARKINSONS DISEASE, LEFT SIDE</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 10, 1966</u> to <u>FEB 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>2-2-1966</u> , and that death occurred at <u>10:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Samuel A. Hillman</u>				22b. DATE SIGNED <u>2-2-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>SAMUEL A. HILLMAN</u>				22d. ADDRESS <u>8829 FLOWER AVE SILVER SPRING MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2-2-66</u>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR <u>W. J. Hillman</u>		ADDRESS		25a. REC'D BY REGISTRAR <u>Feb 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

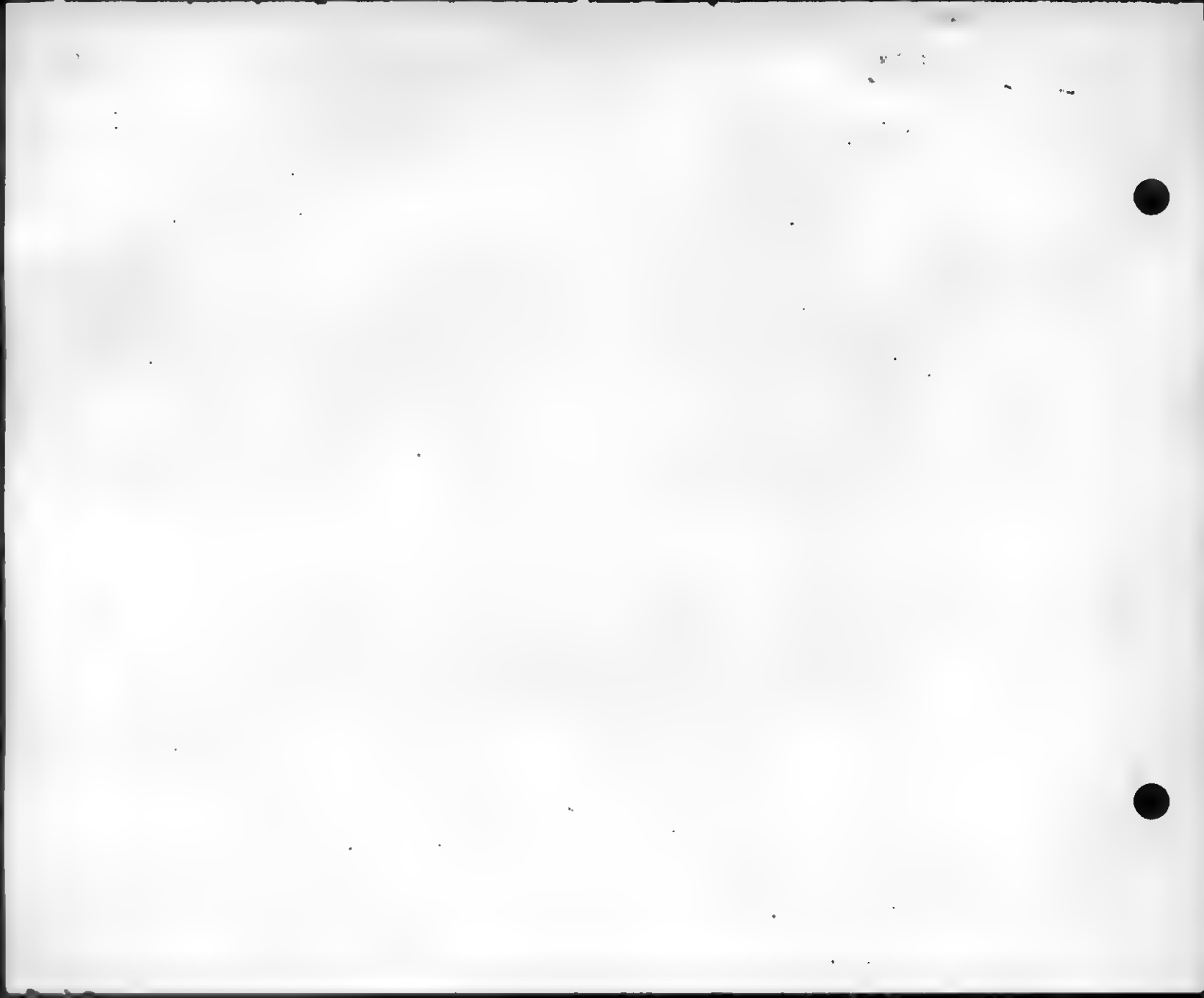
MEDICAL CERTIFICATION



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div> <div> <div>2</div> <div>1</div> </div> <div> <div>FOR STATE</div> <div>HEALTH DEPT.</div> </div> </div> <div> <div>Items 18&amp;21 Film G375 3-21-66 TT</div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> </div> <div> <div>02531</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>112495</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b <u>as above</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>as above</u>			d. STREET ADDRESS <u>2332 Naylor Road, S.E.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Marjorie</u>		First <u>Marjorie</u> Middle <u>NMK</u> Last <u>LADD</u>		4. DATE OF DEATH Month <u>2</u> Day <u>17</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-4-13</u>		9. AGE (In years last birthday) <u>52 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Scotland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canadian</u>			
13. FATHER'S NAME <u>Thomas Begbie</u>				14. MOTHER'S MAIDEN NAME <u>Mary Stewart</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Clifford R. Ladd</u> Same as Item # <u>2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute, right, coronary insufficiency;</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery heart disease</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Belden R. Read</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>BELDEN R. READ, M.D.</u>				Address (Street, City, town or county) <u>Washington, D.C.</u>		22. DATE SIGNED <u>Febr. 17, 1966</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Feb. 19-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>			
24. FUNERAL DIRECTOR <u>Simmons Bros.</u>				ADDRESS <u>Simmons Bros.-1661-Good Hope Rd SE Wash DC</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

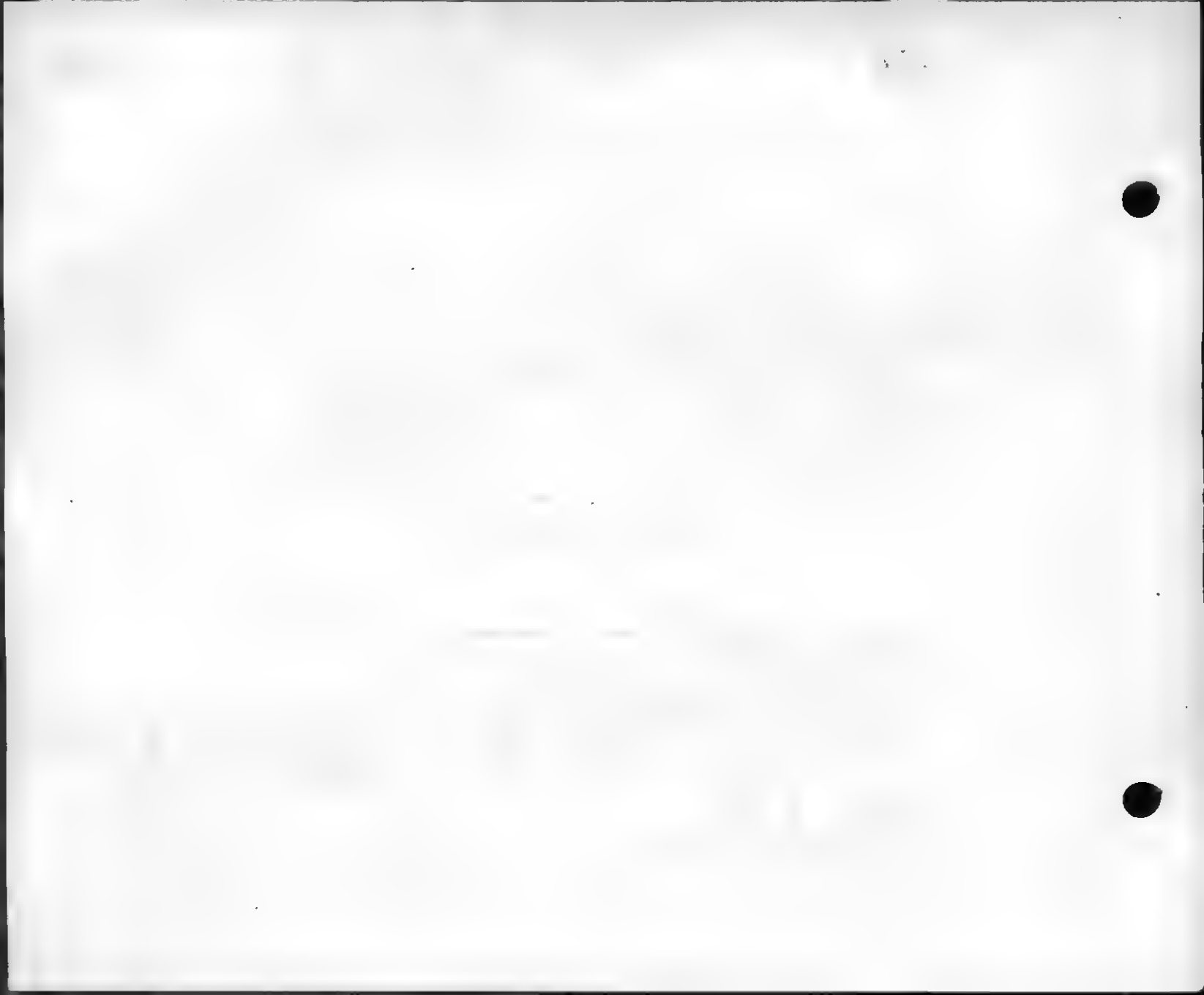
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

02532

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02496

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN ID <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				e. STREET ADDRESS <u>247 Rollins Avenue</u>			
3. NAME OF DECEASED (Type or print) <u>LOUIS I. LANDAU</u>				4. DATE OF DEATH <u>2/21/66</u> Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/1/95</u>	
9. AGE (In years last birthday) <u>70 yrs.</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Post Office Dept.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>SAMUEL COHEN</u>			
14. MOTHER'S MAIDEN NAME <u>LENA LEVINE</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u>NONE</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>MARILYN KUELLER-5967-2 Providence Rd.</u> Address <u>Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) <u>Pulmonary emphysema; Recent myocardial infarction (2 wks)</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary emphysema; Recent myocardial infarction (2 wks)</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>65</u> , to <u>Feb 21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb. 21</u> 19 <u>66</u> , and that death occurred at <u>11:11 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Sidney J. Cohen</u>				22b. DATE SIGNED <u>Feb. 21, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Sidney J. Cohen</u>	
22d. ADDRESS <u>50 W. Edmonston Drive, Rockville, Md.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2/23/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>mt. Judah Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Brooklyn N.Y.</u>	
24. FUNERAL DIRECTOR <u>Gooding Funeral Home</u>				25a. REC'D BY REGISTRAR <u>Feb 25 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with item PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18-21 Film G375 7-171-466  
**MARYLAND STATE DEPARTMENT OF HEALTH**  
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

02533

02497

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Burtonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt. 29 + Briggs - Chaney Rd.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>9509 Woodley Avenue</u> d. STREET ADDRESS <u>Silver Spring</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARTHA FELDMAN LANZA</u>		4. DATE OF DEATH Month <u>Febr.</u> Day <u>14</u> Year <u>1966</u>		5. SEX <u>Fe</u>		6. COLOR OR RACE <u>Cauc</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JAN. 6, 1927</u>		9. AGE (in years last birthday) <u>39</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lab. Technician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>		11. BIRTHPLACE (State or foreign country) <u>Jacksonville, Florida</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John R. Feldman</u>				14. MOTHER'S MAIDEN NAME <u>Benlah Barker</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>265-24-9477</u>		17. INFORMANT Name <u>Francisco M. Lanza</u> Address <u>9509 Woodley Avenue Silver Spring, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute poisoning due to potassium cyanide</u> 1718 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ingestion, apparently self-administered.</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Deceased drank mixture of potassium cyanide in a cola drink.</u> 20c. TIME OF INJURY Month, Day, Year Hour <u>3:00</u> p.m. <u>2/14</u> 1966 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> 20f. (City or town) (County) (State) <u>Silver Spring Montg Md.</u>							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> inspection <input checked="" type="checkbox"/> inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <u>BELDEN R. REAP, M.D.</u> Address (Street, city, town, or county) <u>Silver Spring, Md.</u> 22. DATE SIGNED <u>Febr. 14, 1966</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-17-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>C. Alan Carter</u> Address <u>434 Georgia Avenue Warner E. Pumphrey, Inc. Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

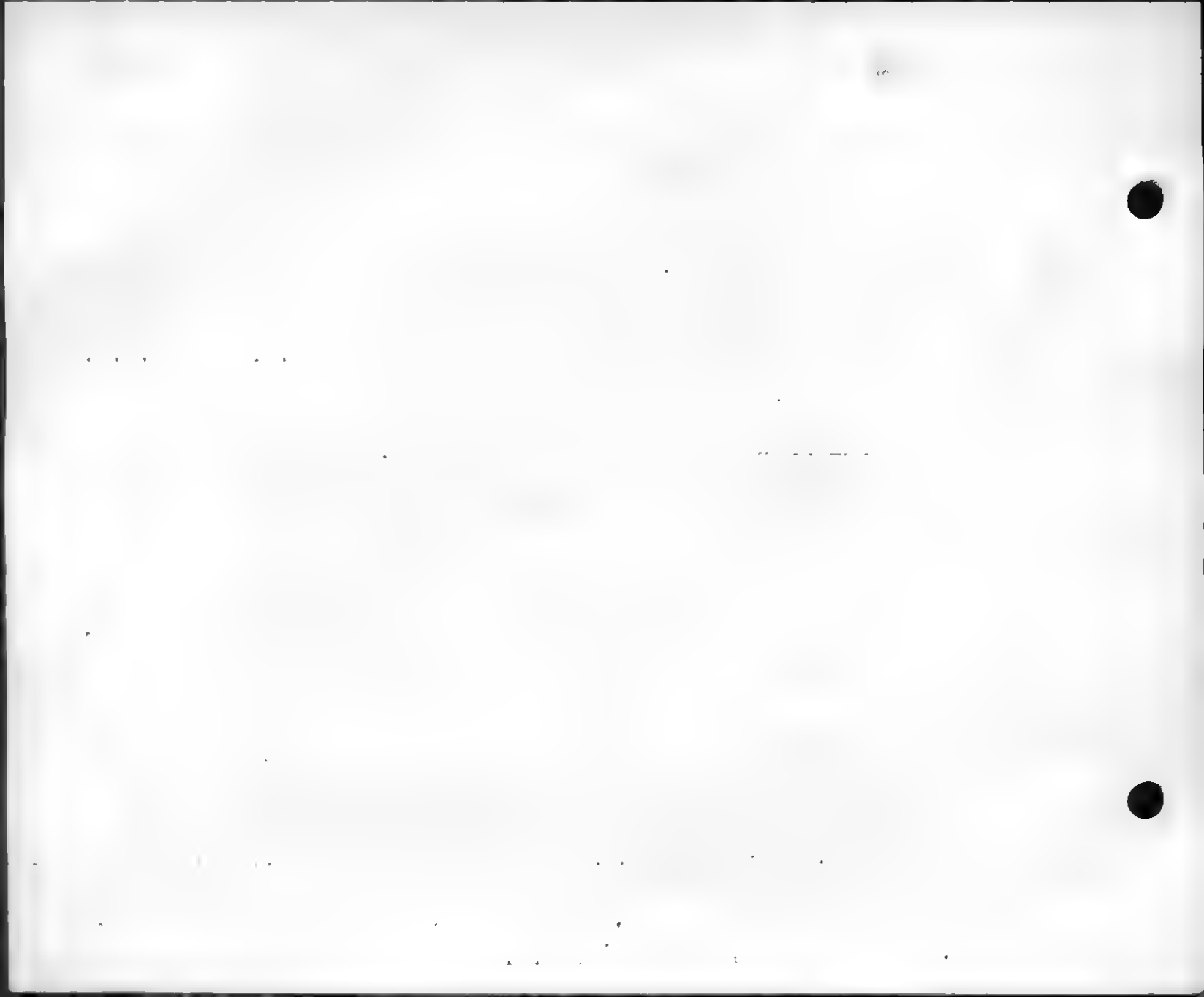
## CERTIFICATE OF DEATH

02534

02498

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hale Center</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15-1</u> d. STREET ADDRESS <u>12608 Eldrid Cr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>JUNE O. Laubscher</u> First Middle Last		4. DATE OF DEATH <u>2 4 1966</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/32</u> 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>
13. FATHER'S NAME <u>George Oberndoerfer</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Lawrence E. Laubscher- Same as #2</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Breast</u> <u>170X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>20 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 85, 19</u> , to <u>2/4, 1966</u> , that (I) (we) last saw the deceased alive on <u>2/3 1966</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>G. Lennard Gold</u>		22b. DATE SIGNED <u>2/4/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>G. Lennard Gold, M.D.</u>		22d. ADDRESS <u>8641 Colesville Rd., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/7/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Com</u>	23d. LOCATION (City, town or county) (State) <u>Prince Georges Md</u>
24. FUNERAL DIRECTOR <u>Jos. Gawler's Sons, Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>2/9 1966</u>	
		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

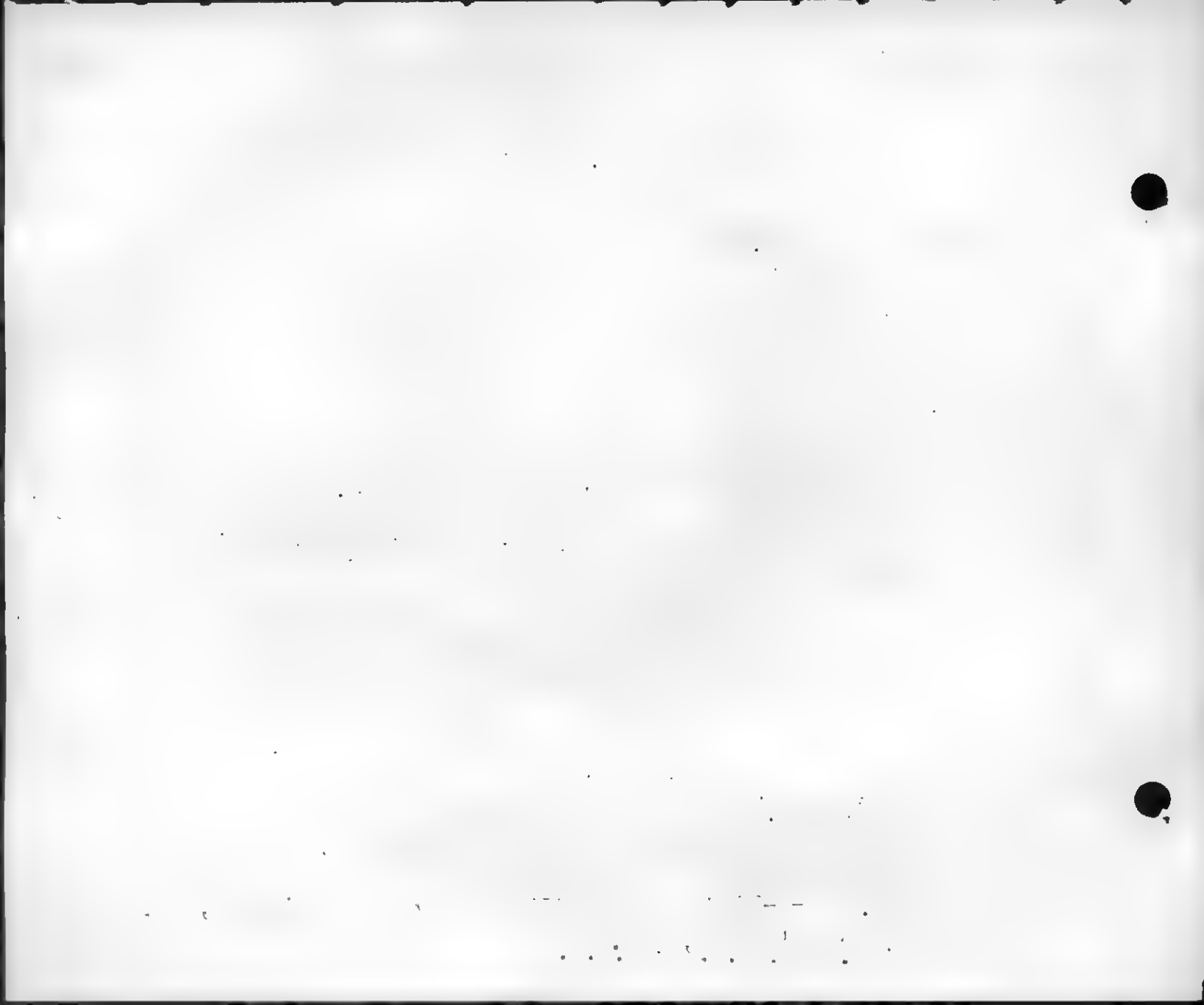


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02535 CERTIFICATE OF DEATH 02499

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>	
c. LENGTH OF STAY IN ID <u>8 days</u>		d. STREET ADDRESS <u>8452 PINEY BRANCH COURT</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Winifred</u> <u>LNMM</u> <u>LAWRIE</u>		4. DATE OF DEATH <u>February</u> <u>28</u> <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>December 23, 1883</u> <u>83</u> yrs.
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Macall</u>		14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFIRMANT <u>Hospital Record</u>		Address <u>-</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN DEATH AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Febr 20, 1966</u> , to <u>Febr 28, 1966</u> , that (I) (we) last saw the deceased alive on <u>Febr 28, 1966</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Eino Magi</u>		22b. DATE SIGNED <u>2-28-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>EINO MAGI</u>		22d. ADDRESS <u>831 University Blvd. E. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>3-3-1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Suitland, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u>		25a. REC'D BY REGISTRAR <u>1966</u>	
ADDRESS <u>5130 Wisc. Ave. N.W., Wash. D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

M

MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02536

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02500

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If not in hospital, write RURAL and give nearest town) <u>Rockville</u>	
c LENGTH OF STAY IN <u>DOA</u>		d STREET ADDRESS <u>10404 Rockville Pike</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Christopher Scott Lechman</u>		4 DATE OF DEATH <u>Feb- 21 1966</u>	
5 SEX <u>Male</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12/22/65</u>
9 AGE (in years last birthday) <u>1</u> yrs		F UNDER 1 YEAR Months <u>2</u> Days <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11 BIRTHPLACE (State or foreign country) <u>Washington, D.C.</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Joseph Lechman</u>		14 MOTHER'S MAIDEN NAME <u>Linda Bachman</u>	
15 WAS DECEASED IN U.S. ARMED FORCES (Yes or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Linda Lechman</u>		Address <u>10404 Rockville Pike Rockville, Maryland</u>	
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY <u>491X</u> IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)		19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>2/21/66</u>	
EXAMINER'S NAME (Type) <u>John G. Ball, M.D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>		23b. DATE THEREOF <u>2/22/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Northwood Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Philadelphia, Pa.</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u>		ADDRESS <u>Bethesda, Md.</u>	
25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

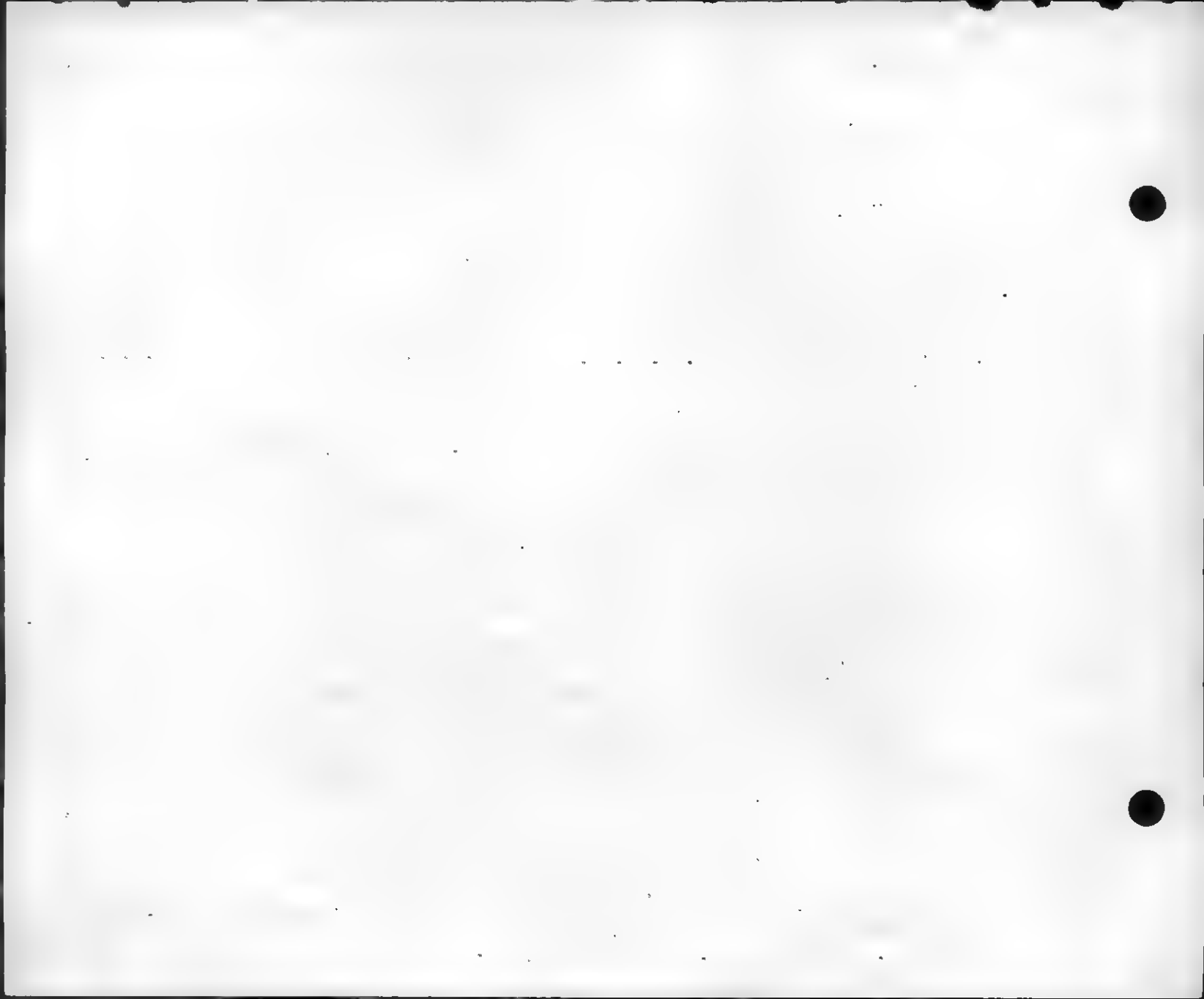


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Cleared with medical examiner - Dr. B. Reap.

<div style="display: flex; justify-content: space-between;"> <div> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div> <div>02501</div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>18 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>321 Branch Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>321 Branch Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>Gerald</u> First <u>Phillip</u> Middle <u>Leicht</u> Last <b>4. DATE OF DEATH</b> <u>February</u> <u>4</u> <u>19</u> <u>66</u>				<b>5. SEX</b> <u>Male</u> <b>6. COLOR OR RACE</b> <u>White</u> <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>March 21, 1908</u> <b>9. AGE</b> (In years last birthday) <u>57</u> yts. <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> <b>IF UNDER 24 HRS.</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Lawyer</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>N. L. R. B.</u> <b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Medford, Wisconsin</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>				<b>13. FATHER'S NAME</b> <u>Herman Leicht</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Anna Stein</u>				<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u> <b>16. SOCIAL SECURITY NO.</b> <u>YES</u> <b>17. INFORMANT</b> <u>Signe R. Leicht</u> Address <u>321 Branch Drive Silver Spring, Maryland</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute cardiac decompensation</u> (b) <u>Rheumatic heart</u> (c) <u>Cerebral thrombosis - right</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u> <b>20c. TIME OF INJURY</b> Month, Day, Year <u>  </u> <u>  </u> <u>19</u> Hour a.m. <u>  </u> p.m. <u>  </u> <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u> <b>20f. (City or town) (County) (State)</b> <u>  </u> <u>  </u> <u>  </u>											
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1953</u> , 19 <u>  </u> , to <u>Feb. 4, 1966</u> , that (I) (we) last saw the deceased alive on <u>Dec. 7</u> , 19 <u>65</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>Bennet A. Porter, Jr.</u> M.D. <b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/> <b>22b. DATE SIGNED</b> <u>Feb. 4, 1966</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>Bennet A. Porter, Jr., M.D.</u> <b>22d. ADDRESS</b> <u>9301 Colesville Rd., Silver Spring Md.</u>											
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Cremation</u> <b>23b. DATE THEREOF</b> <u>2-5-66</u> <b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Fort Lincoln Crematory</u> <b>23d. LOCATION (City, town or county) (State)</b> <u>Prince Georges Co. Maryland</u>											
<b>24. FUNERAL DIRECTOR</b> <u>Warner E. Humphrey, Inc.</u> <b>25a. REC'D BY REGISTRAR</b> <u>  </u> <b>25b. REGISTRAR'S SIGNATURE</b> <u>William J. Judge</u> <b>25c. ADDRESS</b> <u>8434 Georgia Avenue Silver Spring Md.</u> <b>DATE</b> <u>7</u> <u>1966</u>											



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and must be filed within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

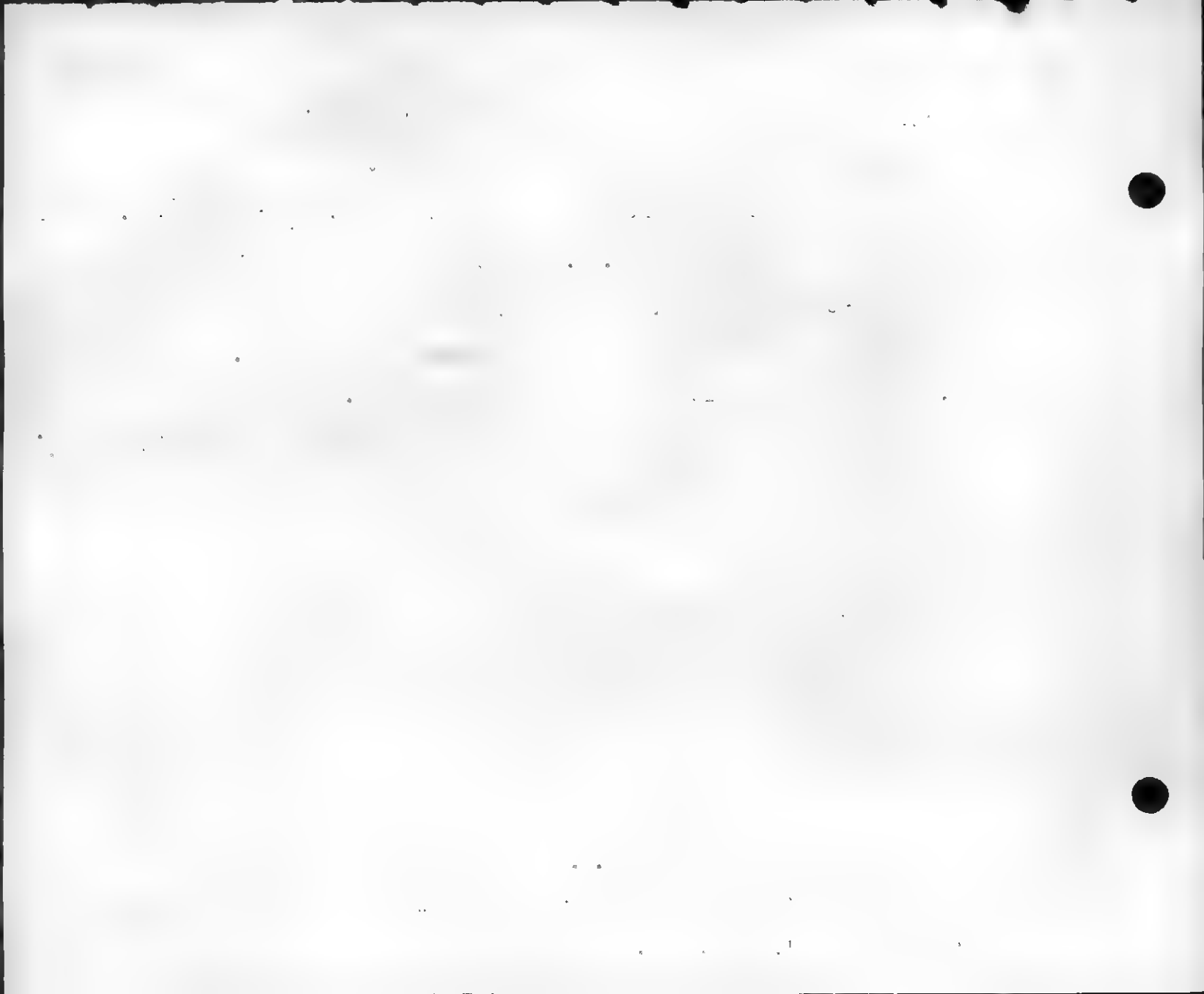
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02538

02502

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b>			<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) STATE <b>District of Columbia</b> COUNTY <b>✓</b>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Resmor Sanitarium &amp; Hospital</b>			d. STREET ADDRESS <b>2122 Massachusetts Ave., N.W.</b>						
<b>3. NAME OF DECEASED</b> (Type or print) First <b>MINNIE</b> Middle <b>H. B.</b> Last <b>LEIGH</b>			<b>4. DATE OF DEATH</b> Month <b>FEBRUARY</b> Day <b>9</b> Year <b>1966</b>						
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>Caucasian</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					
<b>8. DATE OF BIRTH</b> <b>9/27/1871</b>		<b>9. AGE</b> (in years last birthday) <b>94</b> yrs. <table border="1"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Hours</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Hours	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.								
Months	Hours								
<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Grova County, Miss.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>					
<b>13. FATHER'S NAME</b> <b>Dr. Warren F. Barksdale</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Virginia H. MacLaughlin</b>						
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> (Attorney) <b>Mr. Andrew T. Altmann</b> Address <b>501 Colorado Bldg. Washington, D. C.</b>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> 1200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral arteriosclerosis (chronic brain syndrome)</b>									
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. _____ p.m. _____ 19____		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)					
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>					
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>1947</b> , 19____, to <b>2/9/66</b> , 19____, that (I) <del>was</del> last saw the deceased alive on <b>2/5/66</b> 19____, and that death occurred at <b>8:30</b> M, from the causes and on the date stated above.									
<b>22a. SIGNATURE</b> <b>H D Ecker</b>			<b>22b. DATE SIGNED</b> <b>2/9/66</b>		<b>22c. PHYSICIAN'S NAME (Type)</b> <b>HENRY D. ECKER, M.D.</b>				
<b>22d. ADDRESS</b> <b>917 20th St., N.W., Washington, D.C.</b>			<b>22e. ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>						
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Cremation</b>		<b>23b. DATE THEREOF</b> <b>2/10/1966</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Cedar Hill Crematory</b>					
<b>23d. LOCATION (City, town or county)</b> <b>Suitland, Maryland</b>		<b>23e. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							
<b>24. FUNERAL DIRECTOR</b> <b>Joseph Gawler's Sons, Inc. Washington, D.C.</b>									



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

02539

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02503

1 PLACE OF DEATH a. COUNTY <b>Montgomery Co</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY N 16 <b>DOA</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital of Silver Spring</b>		2. USUAL RESIDENCE (Where deceased lived, if inst l'd on Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince Georges</b> c. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town) <b>Laurel</b> d. STREET ADDRESS <b>Laurel, Md.</b> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JOHN M LEISHEAR</b>		4. DATE OF DEATH Month <b>2</b> / Day <b>25</b> / Year <b>1966</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/3/11</b>
9. AGE (In years last birthday) <b>54</b> yrs		10. IF UNDER 1 YEAR Months <b>1</b> Days <b>1</b> Hours <b>1</b> Min <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Government, St. Dept Howard Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Thomas Leishear</b>		14. MOTHER'S MAIDEN NAME <b>Marylee Walker</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-44-9627</b>	
17. INFORMANT <b>JT Leishear-father-same address as deceased</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: <b>4201</b> IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> DUE TO (b) <b>Coronary artery heart disease.</b> DUE TO (c) <b></b> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		9. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>Febr. 25, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-25-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Emmanuel Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Seagoville Md.</b>	
24. FUNERAL DIRECTOR <b>W. W. Donahue, Laurel Md.</b>		25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

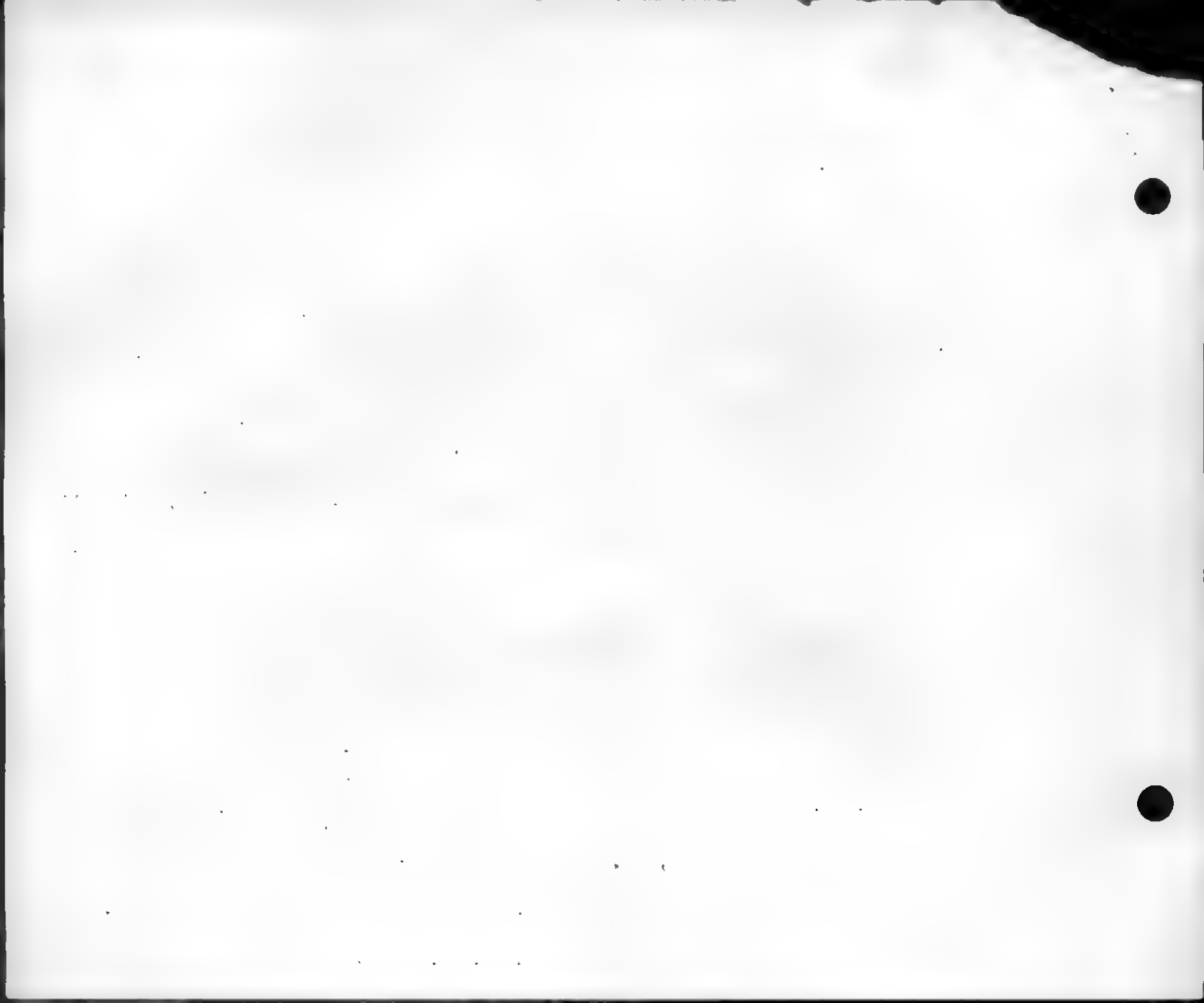




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 21 Film G373 2/11/66 T-1											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02540											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New Jersey</u> <input checked="" type="checkbox"/> b. COUNTY <u>✓</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. LENGTH OF STAY IN 1b <u>11 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Milford</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>						d. STREET ADDRESS <u>355 Lacey Drive</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> <u>(NMN)</u> <u>Levine</u>						4. DATE OF DEATH <u>February</u> <u>4</u> <u>19 66</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>17 August 1906</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Barnett Prager</u>						14. MOTHER'S MAIDEN NAME <u>Bertha Beiderman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>Not Available</u>		17. INFORMANT <u>The Medical Record</u> <u>The Clinical Center, Bethesda 14, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissection of left coronary artery while being/</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>canulated</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>10 Years</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Aortic Stenosis</u> <u>4 Years?</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (a) (this hospital) attended the deceased from <u>24 January, 19 66</u> to <u>4 February 19 66</u> , that (b) (we) last saw the deceased alive on <u>4 February 19 66</u> , and that death occurred at <u>11:00</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Scott Stewart, MD.</u>						22b. DATE SIGNED <u>11:23 AM</u> <u>4 February 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>Scott Stewart, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>2/6/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Israel Mem. Park</u>		23d. LOCATION (City, town or county) (State) <u>Woodbridge, N. J.</u>			
24. FUNERAL DIRECTOR <u>B. DANZANSKY &amp; SONS</u>						25a. REC'D BY REGISTRAR <u>DATE 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02541

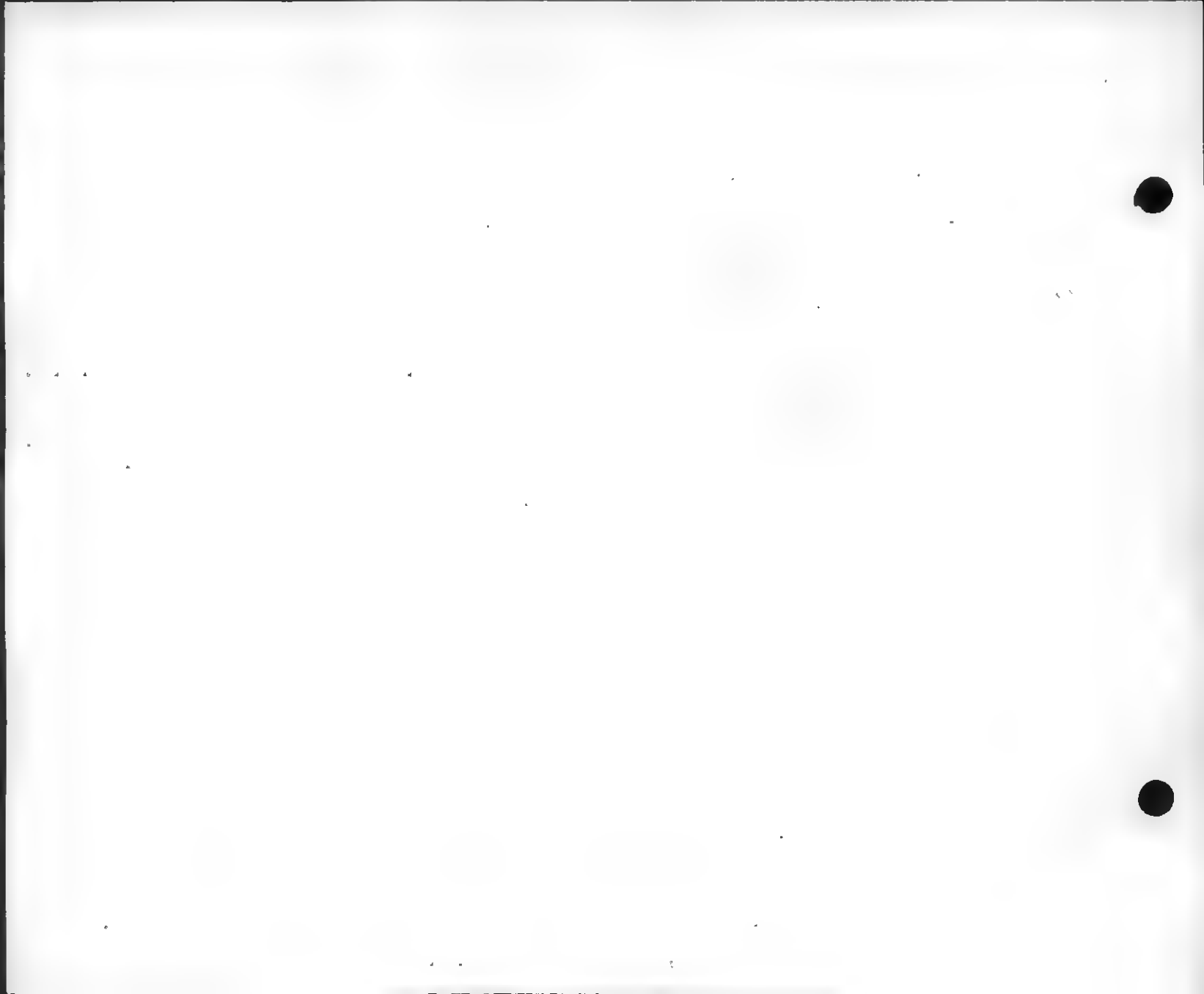
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02505

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1, 2, and 3 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in only one place.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived) b COUNTY <u>Montgomery</u> a STATE <u>Md.</u>	
b CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY IN 1b	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10225 Kensington Pky app 911</u>		d STREET ADDRESS <u>10225 Kensington Pky 911</u>	
3 NAME OF DECEASED (Type or print) <u>Barbara Burke</u> First Middle Last		4 DATE OF DEATH <u>Feb</u> Month Day Year <u>12</u> <u>1966</u>	
5 SEX <u>Fe.</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>12-25-1914</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Computer Programmer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Research</u>	11 BIRTHPLACE (State or foreign country) <u>Neb.</u>
13 FATHER'S NAME <u>Edward Raymond Burke</u>		14 MOTHER'S MAIDEN NAME <u>Nettie Flinn</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16 SOCIAL SECURITY NO <u>—</u>	
17 INFORMANT <u>Lewis Merkt Lind Bethesda, Md.</u>		18 ADDRESS <u>7523 Spring Lake Dr.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carbon Monoxide Inhalation</u> DUE TO (b) <u>Apartment Fire</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u>
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART (a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSES WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) <u>Fell asleep in chair smoking - Chair &amp; Rug caught fire</u>	
20c TIME OF INJURY Month Day Year Hour am <u>7:30 PM</u> <u>2/12</u> <u>1966</u>		20d INJURY OCCURRED While <input type="checkbox"/> at work or hot while <input checked="" type="checkbox"/> at work	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <u>apartment</u>		20f (City or town) (County) (State) <u>Kensington Mont. Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MED. CAL. EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/12/66</u>	
		Address (Street, city, town, or county)	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b DATE THEREOF <u>2-14-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>	23d LOCATION (City or town) (County) (State) <u>Prince George, Md.</u>
24 FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Washington, D.C.</u>		25a REC'D BY REGISTRAR <u>FEB 17 1966</u>	25b REGISTRAR'S SIGNATURE <u>John G. Ball</u>



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
(M)

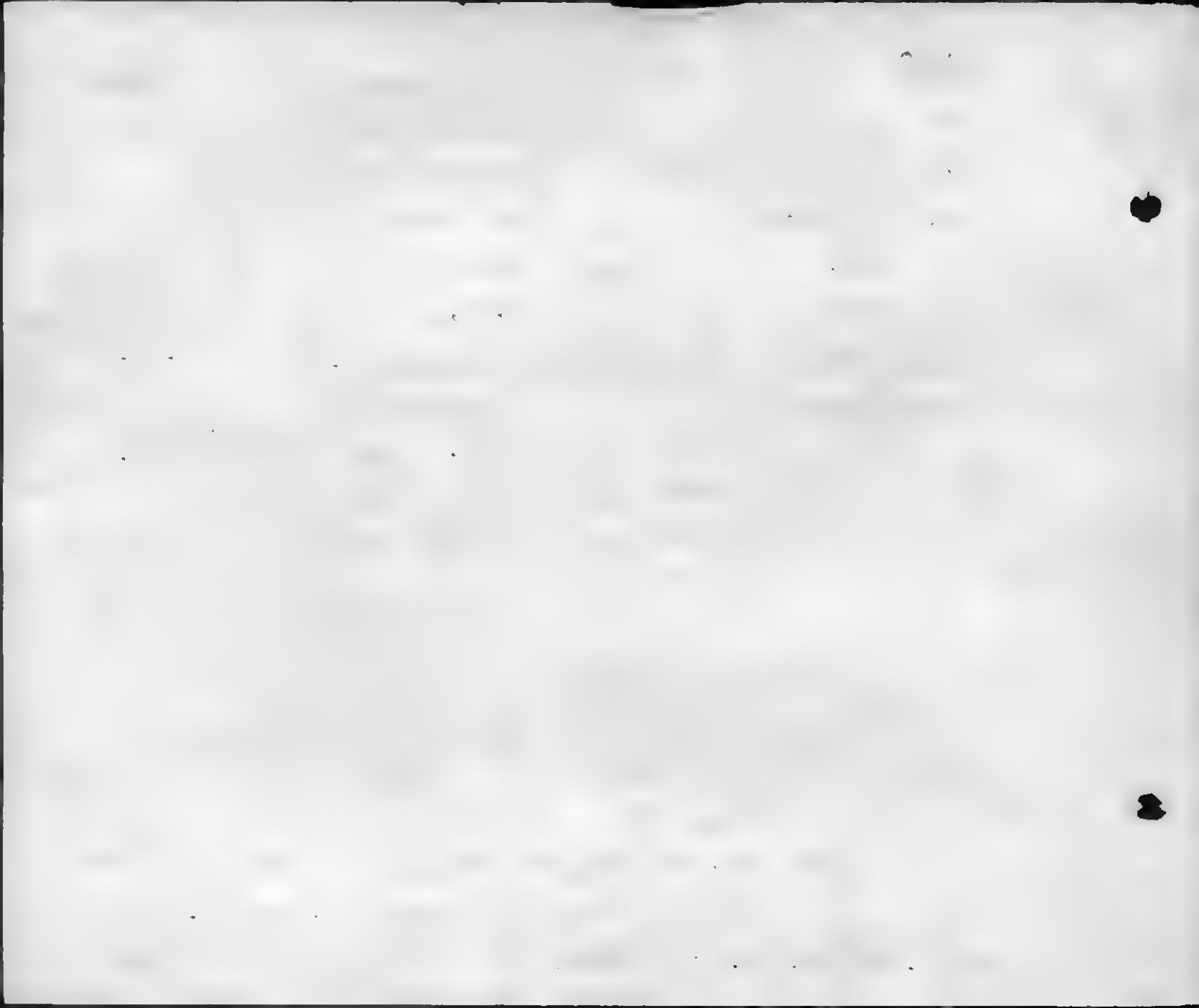
# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH

02542

02506

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b <u>26 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>XXXXX 8317 Draper Lane</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8317 Draper Lane</u>	
3. NAME OF DECEASED (Type or print) <u>Dwight</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 17, 1890</u> 9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		4. DATE OF DEATH <u>Feb 23 1966</u> Month Day Year e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consulting Architect</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Kalamazoo, Mich.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Key Longley</u> 14. MOTHER'S MAIDEN NAME <u>Isabelle Maud</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give number and dates of service) <u>Yes</u> 16. SOCIAL SECURITY NO. <u>Yes</u> 17. INFORMANT <u>Saleeta K. Longley</u> Address <u>8317 Draper Lane Silver Spring, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarct</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day Year Hour a.m. p.m. <u>19</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 2, 1955</u> to <u>Feb. 23, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb. 22, 1966</u> , and that death occurred at <u>2 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John E. Everett</u> 22c. PHYSICIAN'S NAME (Type) <u>JOHN E. EVERETT</u>		22b. DATE SIGNED <u>2/23/66</u> 22d. ADDRESS <u>9400 CONN. AVE. KENSINGTON</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Feb 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Warner E. Pumphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Maryland</u>		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Arley Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02543 CERTIFICATE OF DEATH 02507

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUBURBAN</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GAITHERSBURG</u> d. STREET ADDRESS <u>324 E. DIAMOND AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>F. ELIZABETH LOOMIS</u>		4. DATE OF DEATH Month Day Year <u>FEB 21 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/26/11</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEC</u>	
11. BIRTH PLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William K. Loomis</u>		14. MOTHER'S MAIDEN NAME <u>Frances Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <u>KATHERINE Weils - Sister</u>	
17. INFORMANT <u>KATHERINE Weils - Sister</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Perforated ulcer, peritonitis late</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>perforated ulcer, cirrhotic liver</u> DUE TO (c) <u>cirrhosis (advanced) liver 1 yr</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>1 yr</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-20-66</u> , 19 <u>66</u> , to <u>2-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2-21-1966</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>John O. Robben</u>		22b. DATE SIGNED <u>2-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>John O. Robben M.D.</u>		22d. ADDRESS <u>8007 Shing Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>2-22-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>Lee Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>	
ADDRESS <u>Washington, D.C.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02544

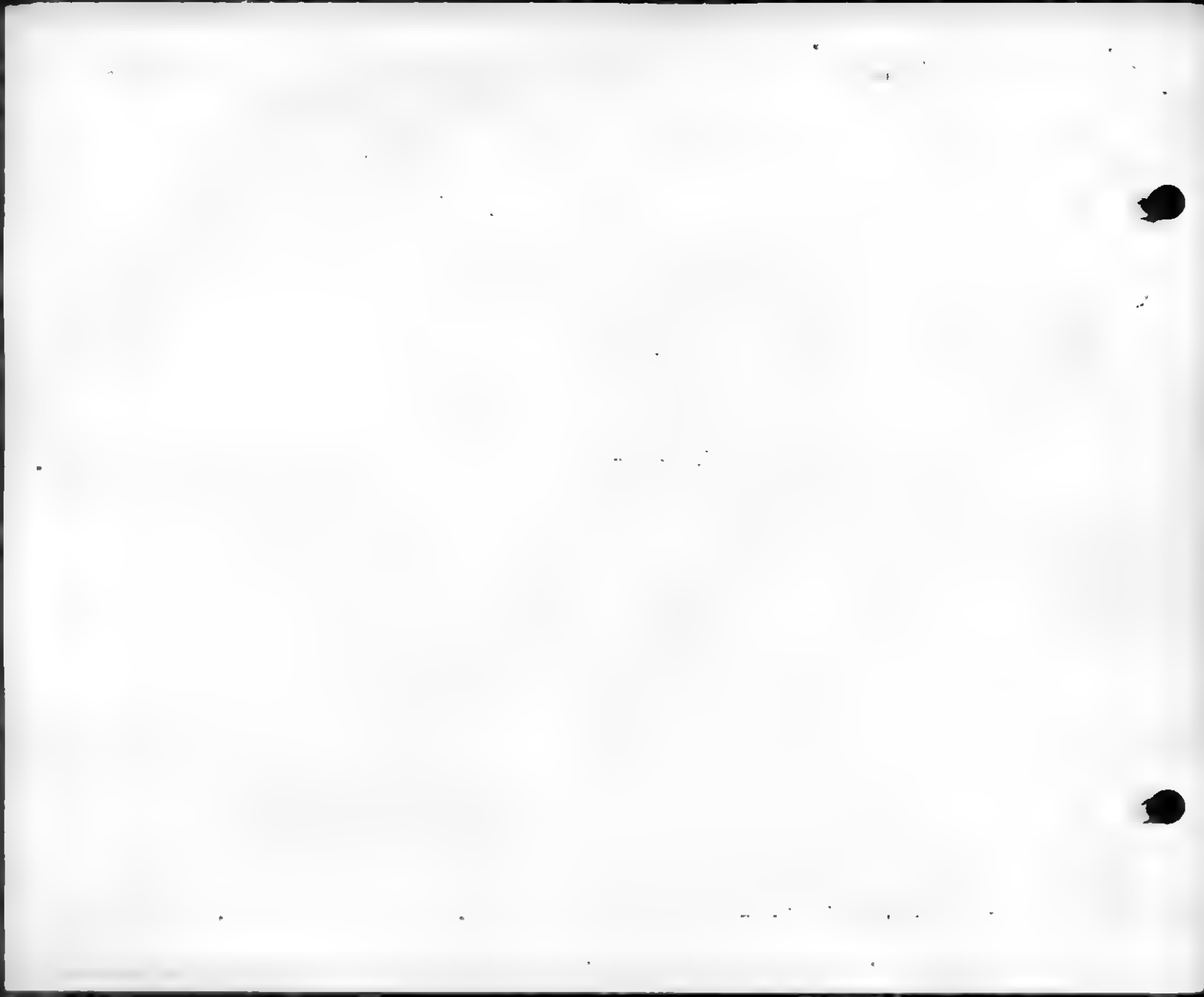
## CERTIFICATE OF DEATH

0250X

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution or residence before admission) a STATE <u>MD</u> b COUNTY <u>Mont.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c LENGTH OF STAY IN 1b <u>1</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d STREET ADDRESS <u>10501 Montrose Ave.</u>	
3 NAME OF DECEASED (Type or print) <u>Raymond H. Lucia</u>		4 DATE OF DEATH <u>2-4</u> 19 <u>66</u>	
5 SEX <u>M</u>	6 COLOR OR RACE <u>W</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>4-16-06</u> 59
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Audio Engineer</u>		10b KIND OF BUSINESS OR INDUSTRY <u>U.S.A.</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>Vermont</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13 FATHER'S NAME <u>Henry R. Lucia</u>		14 MOTHER'S MAIDEN NAME <u>Edith Swift</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) (If yes give war or dates of service) <u>No</u>		16 SOCIAL SECURITY NO. <u>104-09-4121</u>	
17 INFORMANT <u>Glennae - Wife - Same as</u>		Address <u>Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Adenocarcinoma Recto sigmoid</u> 154X DUE TO (b) <u>Colon with metastases</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>24 RS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> to <u>Feb 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>4 Feb</u> , 19 <u>66</u> , and that death occurred at <u>1 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Delwitt E. DeLawter</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Feb 4, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Delwitt E. DeLawter M.D.</u>		22d. ADDRESS <u>3848 BAKER ST NW. WASH. DC.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE THEREOF	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
<u>Burial-transit</u>	<u>2-5-66</u>	<u>White Haven Mem. Park</u>	<u>Pittsburg, New York</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u> ADDRESS <u>Bethesda, Maryland</u>		25a REC'D BY REGISTRAR <u>FEB 14 1966</u> 25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Cleared with medical Examiner R.B.O.

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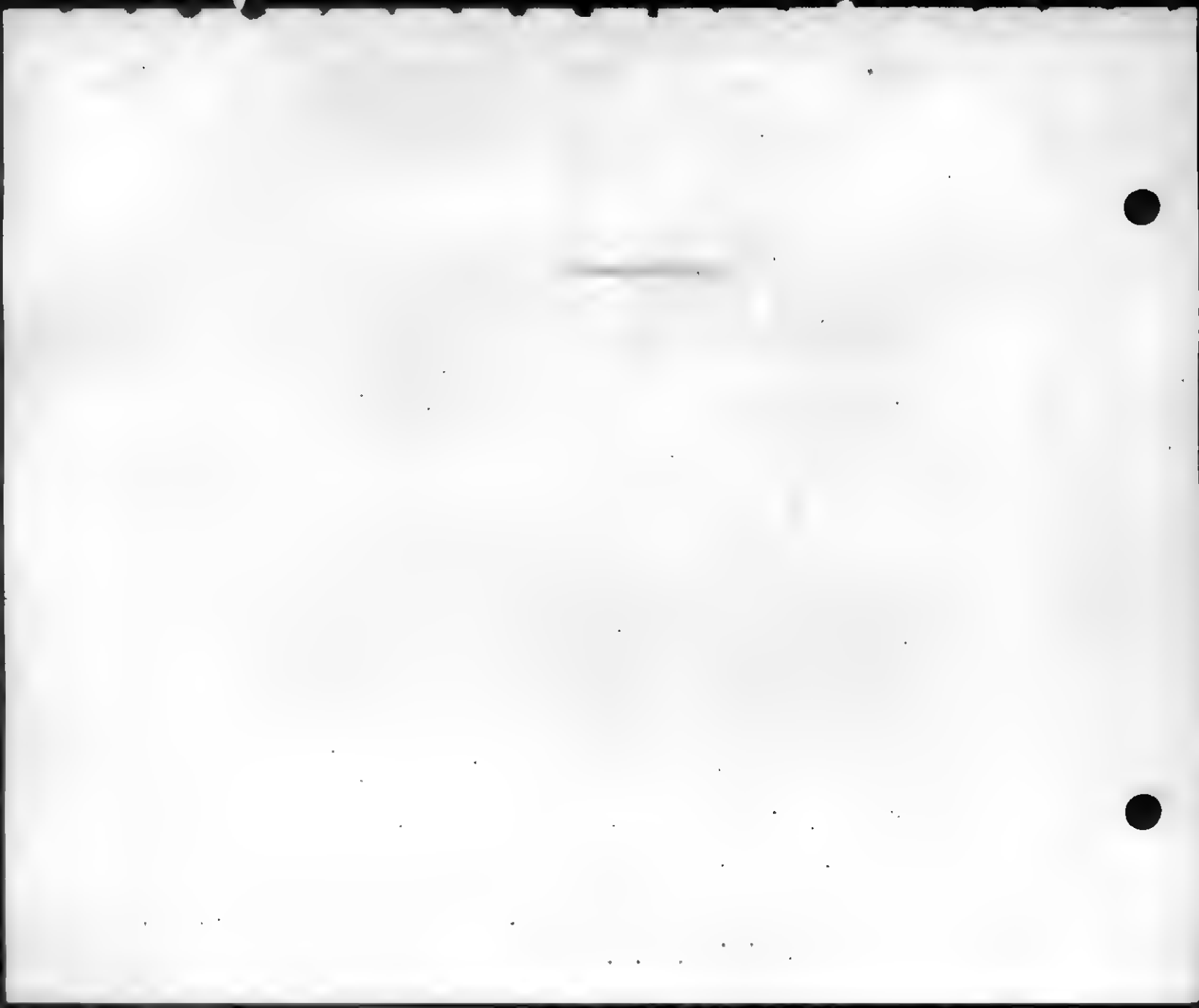
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02545

02509

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San. &amp; Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1023 N. Noyes Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MARY</u> First <u>M</u> Middle <u>-</u> Last <u>LUDWIG</u>	4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1966</u>	5. SEX <u>F</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7-19-88</u> 9. AGE (In years last birthday) <u>77</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <u>Charles</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Knatz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>----</u> (If yes give war or dates of service)	16. SOCIAL SECURITY NO. <u>-----</u>	17. INFORMANT <u>Anna Ballenger (sister)</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 19 <u>57</u> to <u>18 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>18 Jan</u> , 19 <u>66</u> , and that death occurred at <u>1:35 A.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Russell B. Arnold</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/15/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Russell B. Arnold M.D.</u>		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	23b. DATE THEREOF <u>2/17/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>The S.H. Hines Company</u> ADDRESS <u>Washington, D.C.</u>		25a. REC'D BY REGISTRAR <u>5-10-66</u> DATE <u>5-10-66</u> 25b. REGISTRAR'S SIGNATURE <u>W. J. Jones</u>	

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02548

02511

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>11623 LeBaun Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Nathan</u> Middle <u>Margolis</u> Last <u>Margolis</u>		<b>4. DATE OF DEATH</b> Month <u>Feb</u> Day <u>19</u> Year <u>1966</u>		<b>5. SEX</b> <u>male</u>		<b>6. COLOR OR RACE</b> <u>white</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>4/19/91</u>		<b>9. AGE</b> (In years last birthday) <u>74</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>FURRIER</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>GARMENT</u>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Russia</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>MORDECAI MARGOLIS</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>UNKNOWN</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u>				<b>16. SOCIAL SECURITY NO.</b> <u>065-18-1512A</u>				<b>17. INFORMANT</b> <u>HAROLD HELSCHEIN</u> Address <u>(Sewell St 20th)</u>					
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> DUE TO <u>Carcinoma of Bladder</u> (b) <u>  </u> DUE TO <u>  </u> (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u> 19 <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>2/1</u> <u>1966</u> <b>to</b> <u>2/19</u> <u>1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>2/18</u> <u>1966</u> , <b>and that death occurred at</b> <u>7:30 PM</u> , <b>from the causes and on the date stated above.</b>			
<b>22a. SIGNATURE</b> <u>Joseph Bloom</u>						<b>22b. DATE SIGNED</b> <u>2/19/66</u>		<b>22c. PHYSICIAN'S NAME</b> (Type) <u>JOSEPH BLOOM</u>					
<b>22d. ADDRESS</b> <u>1015 SPRING STREET SSANMD</u>						<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>							
<b>23b. DATE THEREOF</b> <u>2/20/1966</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NAT'L. MEM. PARK</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>FALLS CHURCH. VA.</u>					
<b>24. FUNERAL DIRECTOR</b> <u>Goldberg Funeral Home</u> ADDRESS <u>4217-9th St. NW</u>						<b>25a. REC'D BY REGISTRAR</b> <u>FEB 23 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles J...</u>					

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Released by Cover

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02512

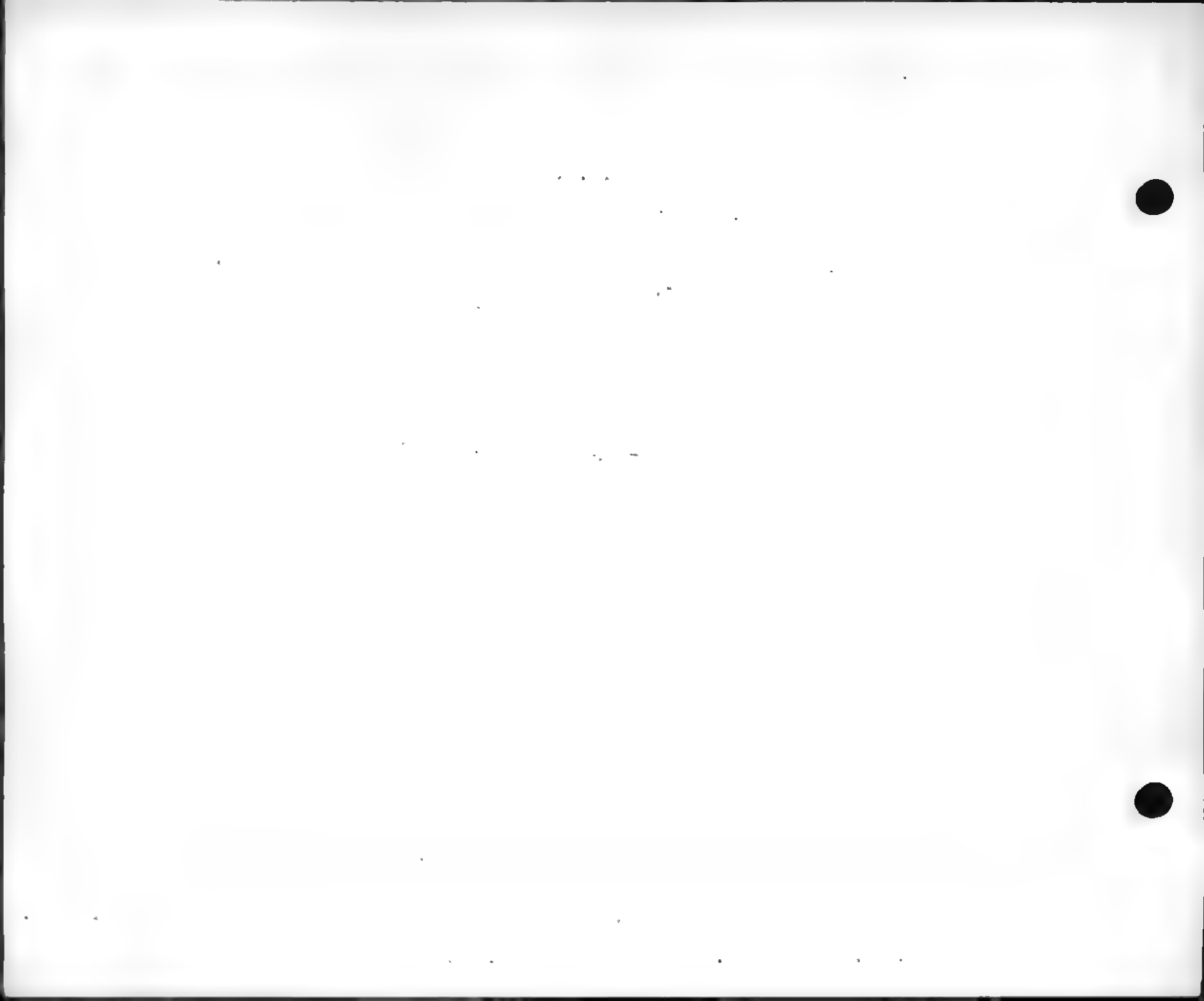
FOR STATE  
HEALTH DEPT.

02547

1 PLACE OF DEATH a COUNTY <b>Montgomery</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if inst. in on Residence before admssion) a STATE <b>Maryland</b> b COUNTY <b>Prince Georges</b>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Takoma Park</b>		c LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Washington Sanitarium &amp; Hospital</b>		e IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <b>Mary Ellen Marion</b>		4 DATE OF DEATH Month <b>Feb.</b> Day <b>21</b> , Year <b>66</b>	
5 SEX <b>F</b>	6 COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-10-04</b>
9 AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <b>hswi</b>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <b>Italy</b>		12 CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13 FATHER'S NAME <b>Louis Pizzuti</b>		14 MOTHER'S M A DEN NAME <b>Josephine Sardellitti</b>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input checked="" type="checkbox"/> or unknown) (If yes give war or dates of service) <b>577-22-6311</b>		16 SOC. A. SECURITY NO. <b>577-22-6311</b>	
17 INFORMANT <b>Mike Marion husband</b>		Address <b>same as #2 above</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage due to ruptured</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>aneurysm at circle of willis: Essential</b> DUE TO (c) <b>hypertension.</b>			INTERVAL BETWEEN ONSET AND DEATH
PART I OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS A TOLPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part I of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED <b>Feb. 21, 1966</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>2/24/66</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Prince Georges Co. Md.</b>	
24 FUNERAL DIRECTOR <b>The S. H. Hines Co. Washington, D. C.</b>		25a REC'D By REGISTRAR <b>FEB 23 1966</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

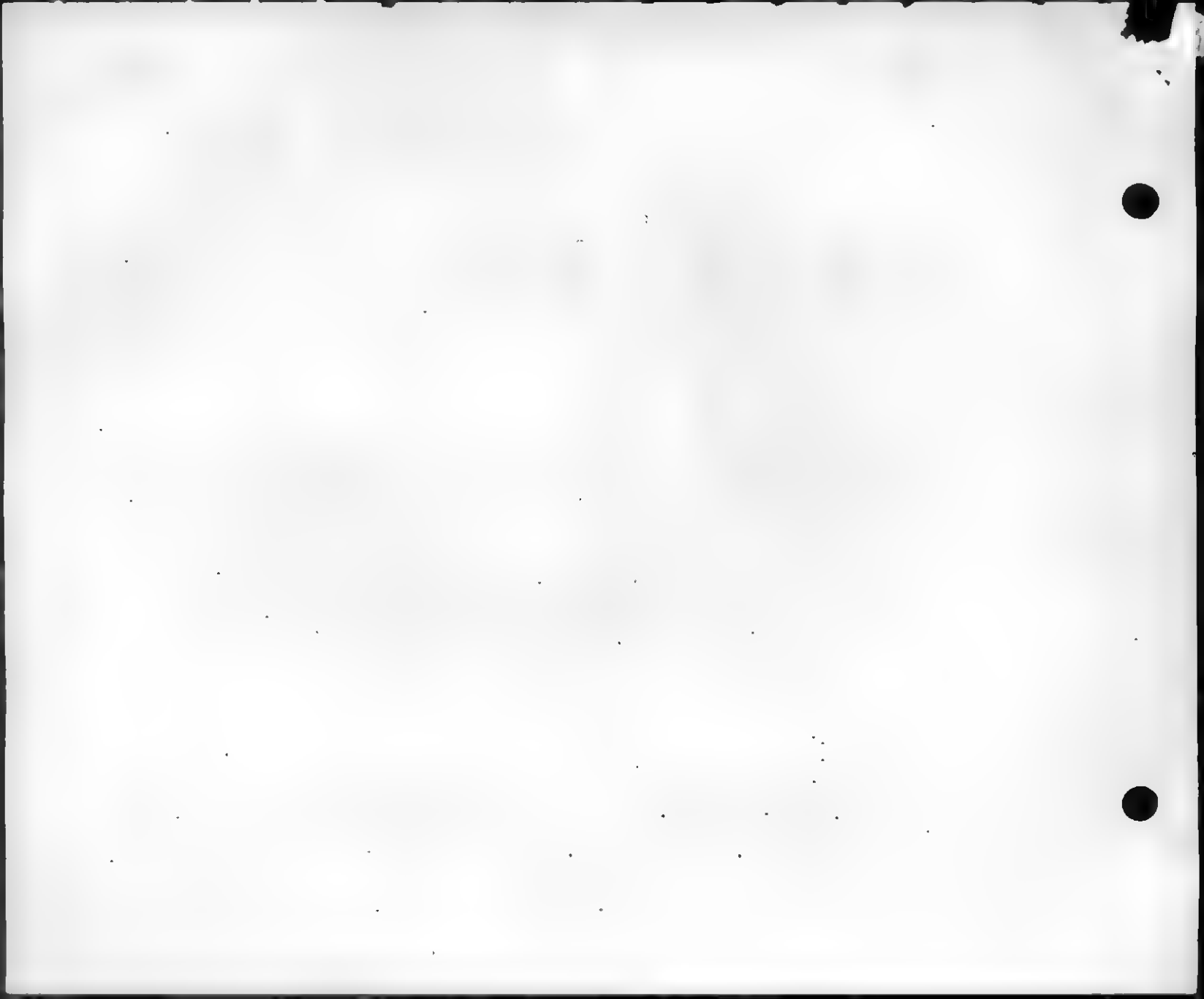
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02513

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Tobacco Park</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wash. San &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Pr. George</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Adelphi</u> d. STREET ADDRESS <u>8228 - 14th Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mr. Jack (Marcovitz) Martin</u> 4. DATE OF DEATH <u>2</u> <u>3</u> <u>1966</u> 5. SEX <u>male</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>11-14-1890</u> 9. AGE (In years last birthday) <u>75</u> yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Rumania</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Jacob Martin</u> 14. MOTHER'S MAIDEN NAME <u>Mollie</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u> 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Hyattsville, Md</u> <u>Mrs. Rose Martin 8228 14th Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute coronary occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic heart disease</u> (c) <u>known 24 yrs</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Anemia, history of Congestive failure</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>24 yrs</u>	
20a. ACCIDENT WAS CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (1) (this hospital) attended the deceased from <u>May 2, 1963</u> to <u>Feb 3, 1966</u> that (1) (we) last saw the deceased alive on <u>Jan 31, 1966</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.	
22a. SIGNATURE <u>John R. Spencer</u> 22c. PHYSICIAN'S NAME (Type) <u>John R. Spencer, M. D.</u> 22d. ADDRESS <u>BUXTONSVILLE, Md.</u>		22b. DATE SIGNED <u>2-3-1966</u> 22e. REC'D BY REGISTRAR <u>Feb 7 1966</u> 22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/6/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Geo. Washington Cem.</u> 23d. LOCATION (City, town or county) (State) <u>Hyattsville Md.</u>		24. FUNERAL DIRECTOR <u>B. DANZANSKY &amp; SONS 3501 14th St. N. W.</u> 25a. REC'D BY REGISTRAR <u>Feb 7 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

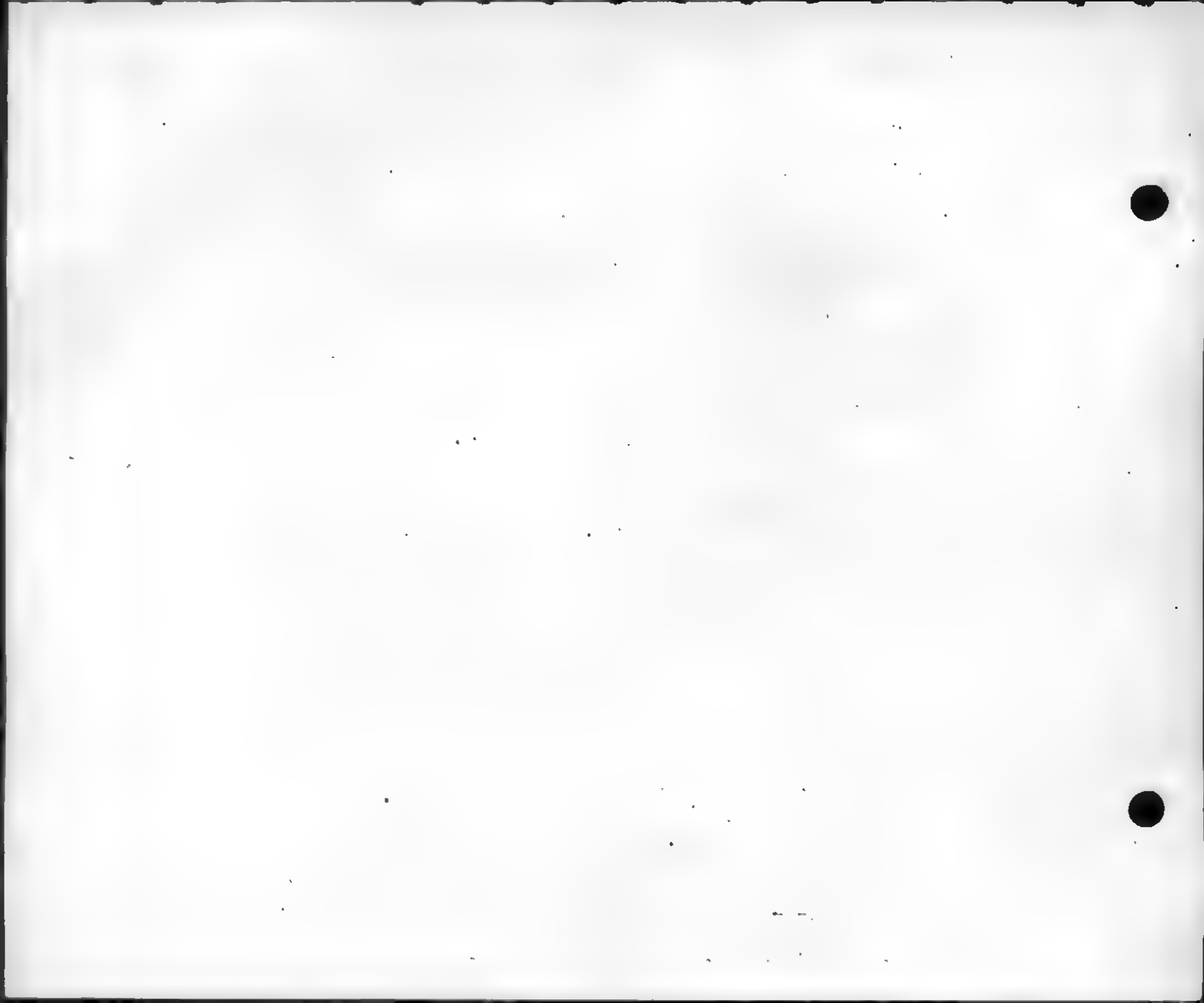
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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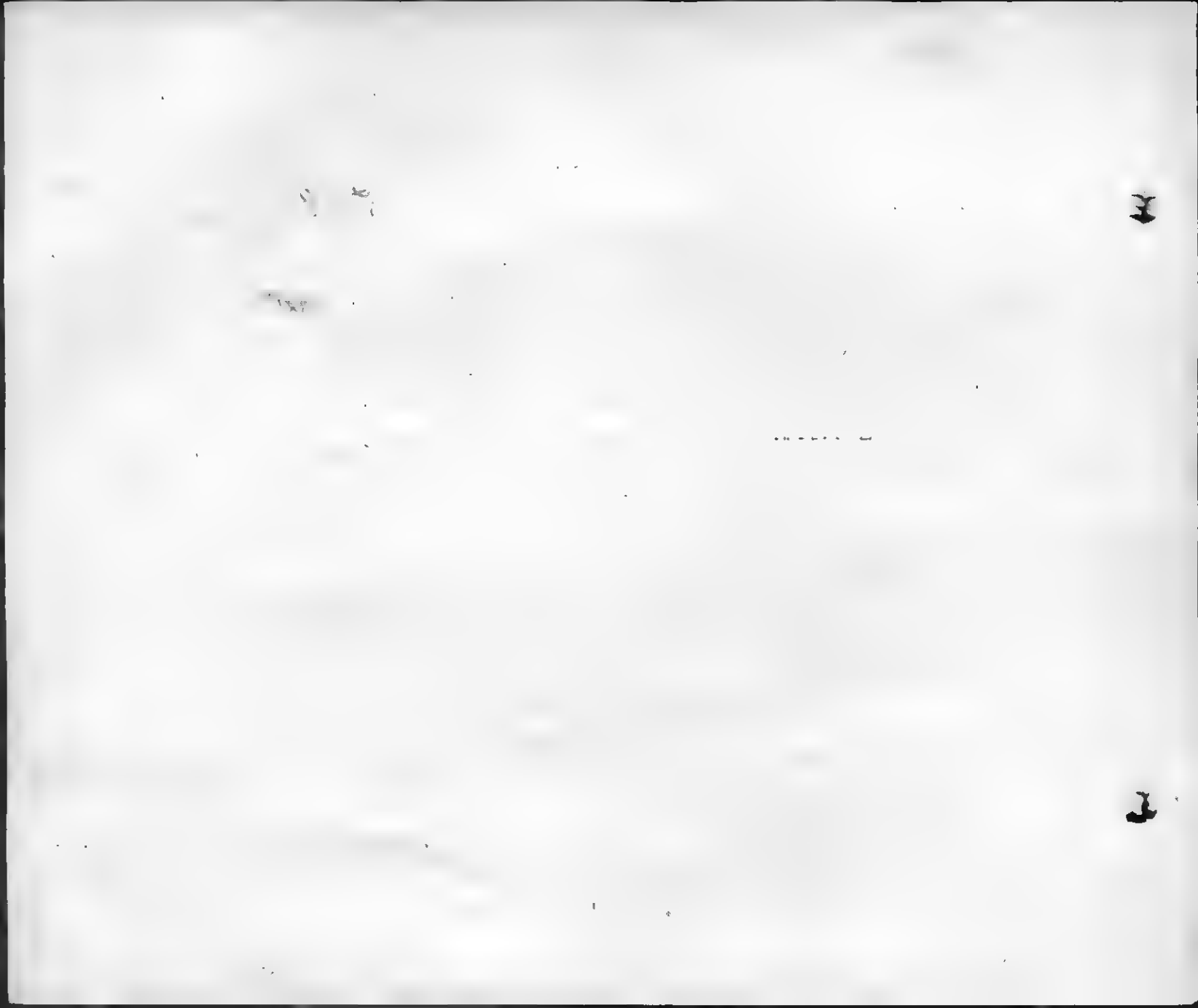


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Cleared & Dr. Reap for Dr. Sherer to sign certificate  
The HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>DOA</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington San + Hosp.</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>1929 East West Hwy #304</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>ROBERT</u> First <u>WALDEN</u> Middle <u>MARTIN</u> Last 5. SEX <u>M</u> 6. COLOR OR RACE <u>W.</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-16-22</u> 9. AGE (in years last birthday) <u>43</u> yrs. 10. FUNDER 1 YEAR <u>Months</u> Days Hours Min. 11. BIRTHPLACE (County & State, or foreign country) <u>Farmington W. Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Jasper David Martin</u> 14. MOTHER'S MAIDEN NAME <u>Frances Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>WW 2</u> 16. SOCIAL SECURITY NO. <u>226-26-9252</u> 17. INFORMANT <u>Dorothea Carol Martin</u> Address <u>1929 East 1st Highway Silver Spring, Md.</u>						18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Primary Myocardial disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u> 3 years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from <u>6/14</u> , 19 <u>65</u> , to <u>2/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>66</u> , and that death occurred at <u>7A</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Max G. Sherer</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>MAX G. SHERER MD</u> 22d. ADDRESS <u>800 Pershing Dr. Silver Spring Md</u>						22b. DATE SIGNED <u>2/5/66</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-8-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>						24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u> ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u> 25a. REC'D BY REGISTRAR <u>FEED</u> 25b. REGISTRAR'S SIGNATURE <u>W. M. J. Judge</u>					





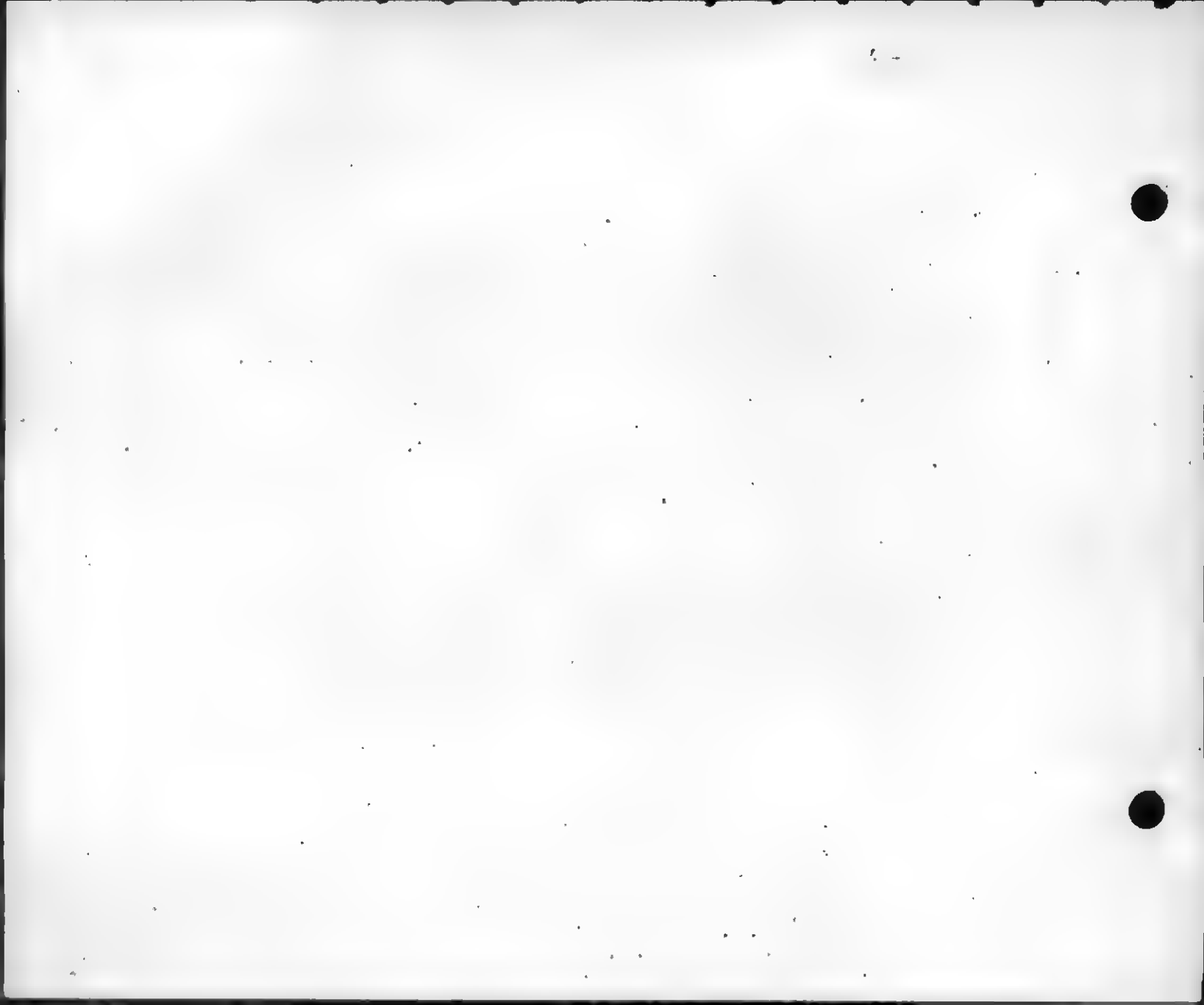


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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02551 CERTIFICATE OF DEATH 02516

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>301 Arcola Ave.</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Hummer Nursing Home</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>New Mexico</b> b. COUNTY <b>Albuquerque</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>3006 9th Street</b> d. STREET ADDRESS <b>3006 9th Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>LeRoy McDowell</b> First Middle Last		4. DATE OF DEATH <b>2 11 19 66</b> Month Day Year	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/2/93</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired manager Columbia Wholesalers Washington, D.C.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>	
13. FATHER'S NAME <b>James H. McDowell</b>		14. MOTHER'S MAIDEN NAME <b>Louanna Pusey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>--</b>		16. SOCIAL SECURITY NO. <b>579-05-1136</b>	
17. INFORMANT <b>Mae McD. Hummer</b>		Address <b>Kensington, Md. 4611 Saul Rd.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Generalized Arteriosclerosis</b> DUE TO (b) <b>Stroke</b> DUE TO (c) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>3 year</b> <b>10 yrs.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 10, 1964</b> to <b>Feb 14, 1966</b> , that (I) (we) last saw the deceased alive on <b>Feb 13, 1966</b> , and that death occurred at <b>10:30 A.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>William Brainin M.D.</b>		22b. DATE SIGNED <b>2/14/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>NM BRAININ</b>		22d. ADDRESS <b>6124 Central Ave, Capital Bldg</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>		23b. DATE THEREOF <b>2/16/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>	
24. FUNERAL DIRECTOR <b>The S.H. Hines Company</b> <b>Washington, D.C.</b>		25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02552

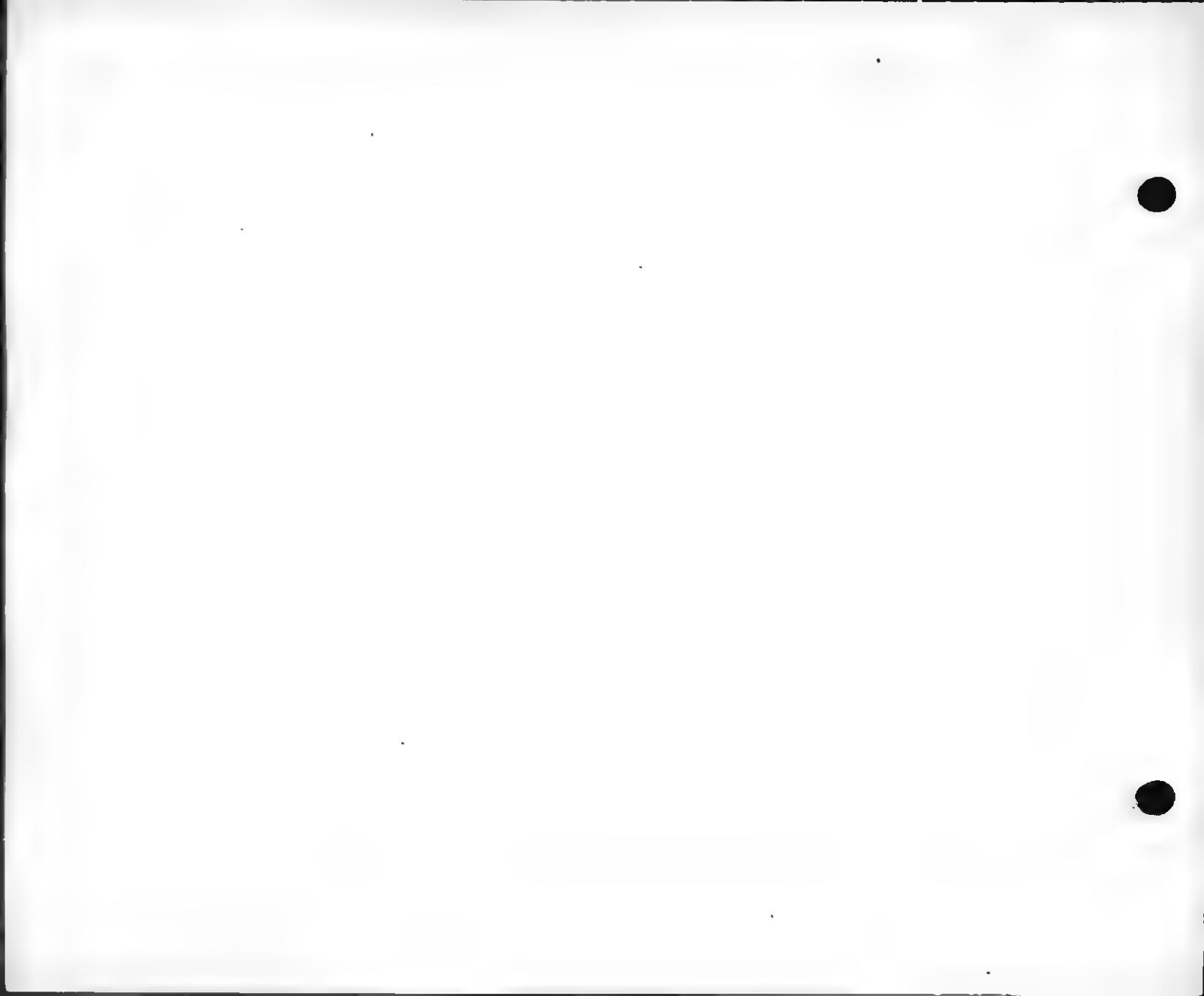
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FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Prince George</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY in 1b. <b>1 1/2 hr.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>		d. STREET ADDRESS <b>Lot #3- Melwood Mobile Homes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Elmer Edward</b> Last <b>McKenzie</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>27</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/06/40</b>	9. AGE (In years last birthday) <b>25</b> yrs	IF UNDER 1 YEAR Months <b>2</b> Days <b>16</b>	IF UNDER 24 HRS Hours <b>2</b> Min <b>00</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Master fencer</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>John Francis McKenzie</b>				14. MOTHER'S M maiden name <b>Ruth E. Kidwell</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-38-5287</b>		17. INFORMANT <b>Ruth Montgomery Lander</b> Address <b>2506 - Marlboro</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Subarachnoid hemorrhage with brainstem compression</b> DUE TO (b) <b>due to automobile accident</b> DUE TO (c) <b>lost</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <b>Passenger in truck that struck bridge abutment.</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:15 p.m. 2/27 1966</b>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>Highway 495</b>		20f. (City or town) (County) (State) <b>Bethesda Mont. Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>John B. Ball</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>2/28/66</b>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cem</b>		23d. LOCATION (City or Town) (County) (State) <b>Switzland Md</b>	
24. FUNERAL DIRECTOR <b>Lee Funeral Home 300-4 ST. NE. D.C.</b>				25a. REC'D BY REGISTRAR <b>MAR 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

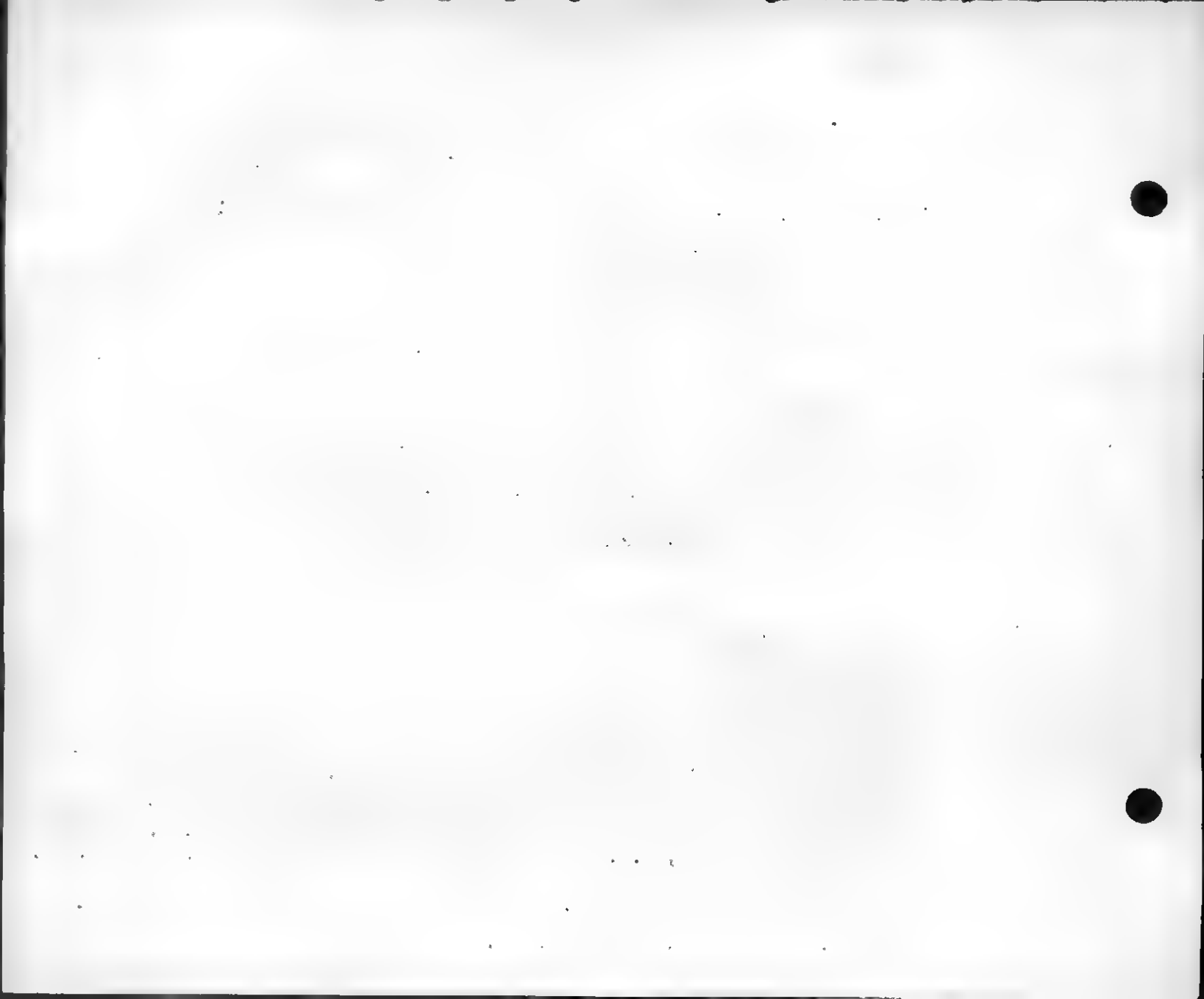
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN lb <u>10 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>The Clinical Center, Bethesda 14, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>26007 Woodfield Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) First <u>Michael</u> Middle <u>Bryan</u> Last <u>McSweeney</u>			4. DATE OF DEATH Month <u>February</u> Day <u>17</u> Year <u>19 66</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>White</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		
8. DATE OF BIRTH <u>15 January 1959</u>			9. AGE (In years last birthday) <u>7</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Bernard E. McSweeney</u>			14. MOTHER'S MAIDEN NAME <u>Frances M. Colebank</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			16. SOCIAL SECURITY NO. <u>None</u>		
17. INFORMANT <u>The Medical Records</u>			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Left heart failure with cardiac arrest</u> DUE TO (b) <u>Constriction of descending aorta</u> DUE TO (c) <u>since birth</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			19. INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			20. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Rubella syndrome 026X</u>			21. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)			21. I certify that (I (this hospital) attended the deceased from <u>February 7, 1966</u> to <u>February 17, 1966</u> , that (I (we) last saw the deceased alive on <u>February 17, 1966</u> , and that death occurred at <u>11:29 A.M.</u> from the causes and on the date stated above.			22a. SIGNATURE <u>Scott Stewart</u>			22b. DATE SIGNED <u>17 February 1966</u>			22c. PHYSICIAN'S NAME (Type) <u>Scott Stewart, M.D.</u>		
22d. ADDRESS <u>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</u>			23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Feb. 21, 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Michael's</u>			23d. LOCATION (City, town or county) (State) <u>Poplar Springs, Md.</u>		
24. FUNERAL DIRECTOR <u>Olin L. Molesworth, Damascus, Md.</u>			25a. REC'D BY REGISTRAR <u>FEB 21 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>								

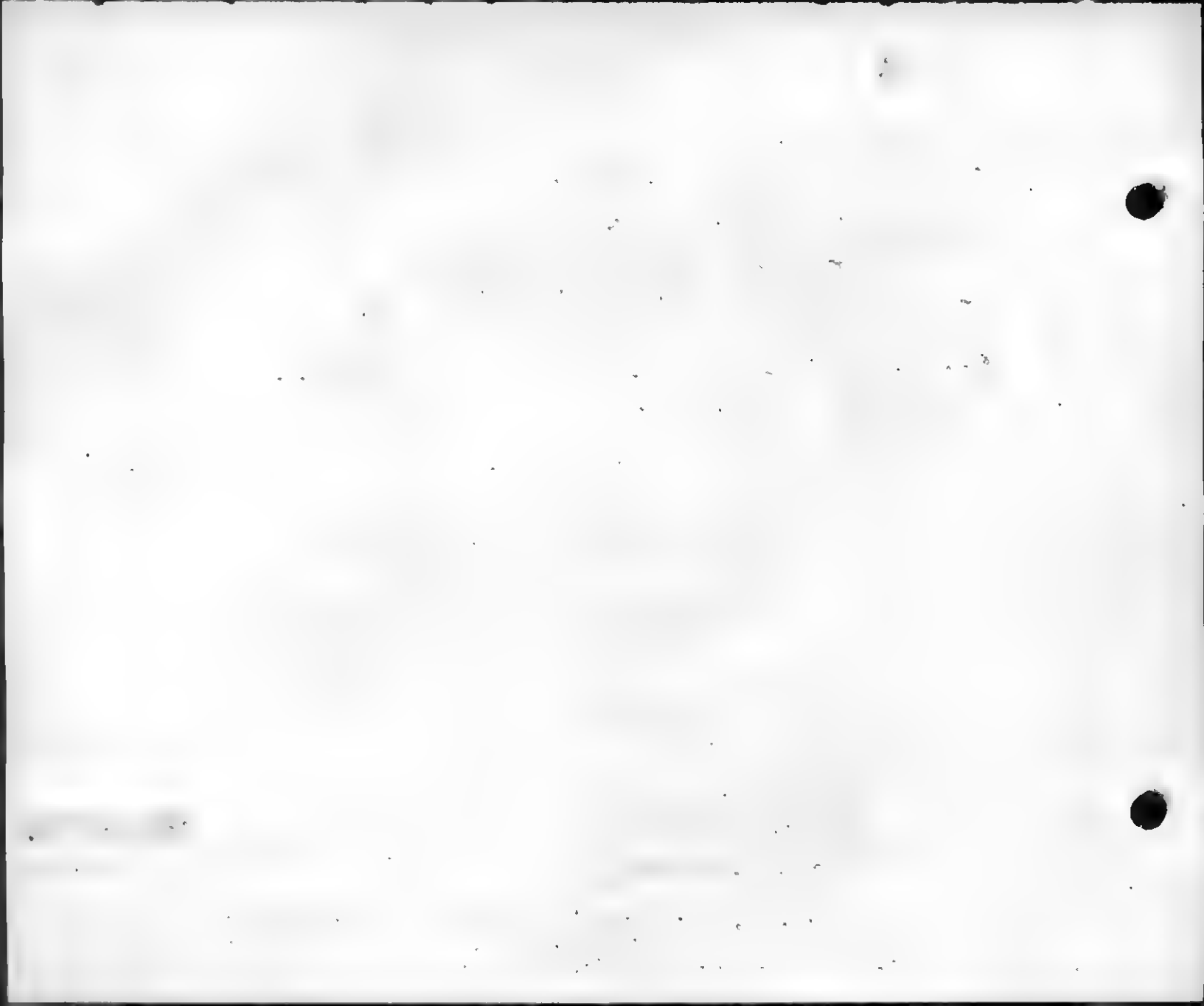


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>		c. LENGTH OF STAY IN 1b <b>2 MONTHS 12 DAYS</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Montgomery</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>SILVER SPRING</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Fairland Nursing Home</b>						d. STREET ADDRESS <b>12804 Matey Rd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>THOMAS MICHAEL McVerry</b>		4. DATE OF DEATH Month <b>2</b> Day <b>22</b> Year <b>1966</b>		5. SEX <b>M.</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-1890</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>2</b> Days <b>22</b> Hours <b>19</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>DETECTIVE SARGEANT D.C. Police</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Washington D.C.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Michael McVerry</b>						14. MOTHER'S MAIDEN NAME <b>Emma Desimore</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-48-7913</b>		17. INFORMANT <b>Mrs. Emma Desimore</b>		Address <b>12806 Matey Road Silver Spring, Md.</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO (b) <b>Coronary arteriosclerosis</b> DUE TO (c) <b>5 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from <b>December 1965</b> to <b>Feb 22, 1966</b> , that (2) (we) last saw the deceased alive on <b>Feb 22, 1966</b> , and that death occurred at <b>5:25 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Michael R. Dobridge</b>						22b. DATE SIGNED <b>FEB 22, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Michael R. Dobridge</b>		22d. ADDRESS <b>12600 Parkland Dr. Rockville</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 25, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Suitland, Md.</b>		23e. REC'D BY REGISTRAR <b>FEB 28 1966</b>		23f. REGISTRAR'S SIGNATURE <b>J. Harley Judge</b>	
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc. 8434 Georgia Ave. Silver Spring, Md.</b>											



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

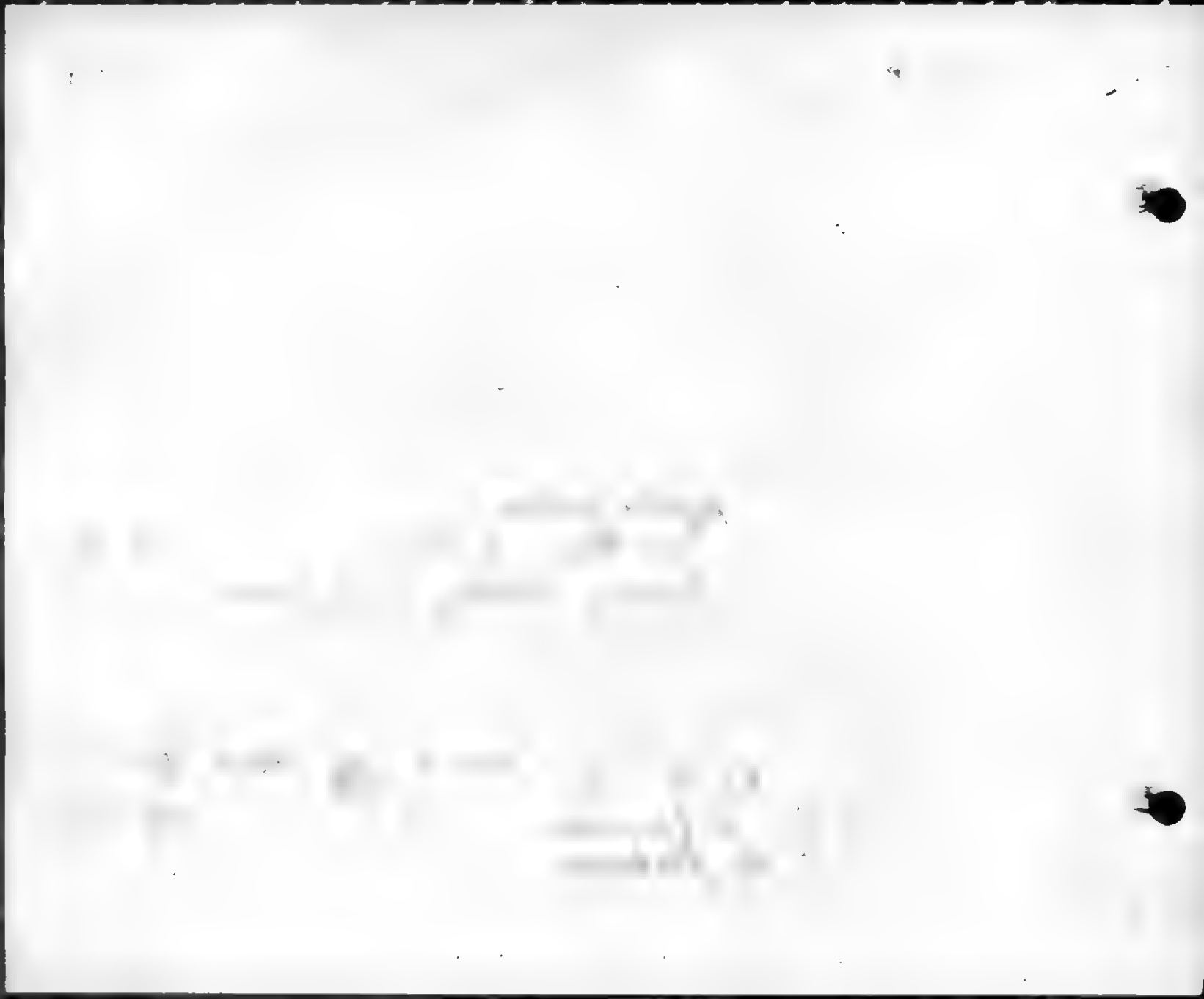
02555

02520

1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		d. STREET ADDRESS <u>9611 W. Bexhill Dr</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type at print) First <u>C</u> Middle <u>Wayne</u> Last <u>Meade</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>19</u> Year <u>1966</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/07</u>
9 AGE (In years last birthday) <u>58</u> yrs		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>9</u>	11. IF UNDER 24 HRS Hours <u></u> Min <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Asst. Mgr. Theatrical</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Asst. Mgr.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Michigan</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Meade</u>		14. MOTHER'S MAIDEN NAME <u>Winnie Betty</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Cliff Luginia</u>		Address <u>SAME</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Negative followup</u> DUE TO <u>10</u> (b) <u>Cirrhosis of liver</u> DUE TO <u>Meningeal hemorrhage</u> (c) <u>Meningeal hemorrhage</u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18, 1966</u> to <u>Feb 19, 1966</u> that (I) (we) last saw the deceased alive on <u>Feb 19, 1966</u> and that death occurred at <u>11:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>V.C. de Guzman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>Feb 19, 1966</u>
22c. PHYSICIAN'S NAME (Type) <u>V. C. de GUZMAN</u>		22d. ADDRESS <u>1150 CONNECTICUT AVE, N.W., WASH. D.C.</u>	
23a. BURIAL, CREMATION, <u>CREMATION</u>	23b. DATE THEREOF <u>2/21/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24. FUNERAL DIRECTOR <u>Robert A. Pumphrey</u> <u>Bethesda, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of any event, within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. **02521**

**02556**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>Silver Spring</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>311 Eldrid Drive</b>		d. STREET ADDRESS <b>311 Eldrid Drive</b>	
3. NAME OF DECEASED (Type or print) <b>Sadie E. Meiselman</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 1, 1883</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Nathan J. Wickner</b>		14. MOTHER'S MAIDEN NAME <b>Rosa S. Milrad</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>045 16 5279</b>	
17. INFORMANT <b>Son</b>		Address <b>Md. S. Harry Meiselman-211 Eldrid Dr., S. S.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis with Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>3 years</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. ft. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb 16, 1966</b> to <b>Feb 17, 1966</b> , that I last saw the deceased alive on <b>Feb 16, 1966</b> , and that death occurred at <b>12:45 AM</b> , from the causes and on the date stated above ADDRESS (Street, city or town, state) <b>9210 Coleridge Rd., Silver Spring, Md.</b> DATE SIGNED <b>2/17/66</b> ACTUAL SIGNATURE <b>Sydney Leventhal, M.D.</b> PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M.D. Silver Spring, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/66</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden Falls Church, Virginia</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>B. Langensky + Son</b>		ADDRESS <b>3501 14th St. N.W. Wash. D.C.</b>	
24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

02557

02522

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <b>Md.</b>		b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ROCKVILLE</b>		d. STREET ADDRESS <b>1006 GILBERT RD.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Congressional Manor Nursing Home</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. DATE OF DEATH <b>2ND 22ND 1966</b>	
1. NAME OF DECEASED (Type or print) <b>Frances</b>		2. DATE OF BIRTH <b>Mezebish</b>		3. AGE (In years last birthday) <b>63 yrs.</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Russia</b>	
13. FATHER'S NAME <b>Nathan Goodman</b>		14. MOTHER'S MAIDEN NAME <b>Anna ? UNKNOWN</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>SON BURTON MEZEBISH, SAME</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>Endometrial Carcinoma</b> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 9 mos</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Rockville</b>		(County) <b>Montgomery</b>		(State) <b>Md.</b>	
21. I certify that (I) (this hospital) attended the deceased from <b>MAY 24, 1965</b> to <b>Feb 22, 1966</b> that (I) <del>and</del> last saw the deceased alive on <b>2/4</b> , 19 <b>66</b> and that death occurred at <b>2:30 PM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>A.C. MAGANZINI</b>		22b. DATE SIGNED <b>2/24/66</b>		22c. PHYSICIAN'S NAME (Type) <b>A.C. MAGANZINI</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>2/24/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH ISRAEL CEM.</b>	
23d. LOCATION (City, town or county) <b>NEW HAVEN</b>		(State) <b>CONN.</b>		24. FUNERAL DIRECTOR'S SIGNATURE <b>Goldberg Funeral Home</b>	
25a. REC'D BY REGISTRAR <b>Feb 25 1966</b>		25b. REGISTRAR'S SIGNATURE <b>J. A. Jones</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

med. Exam. by the local medical officer is not required in a non-hospital death.

MEDICAL CERTIFICATION

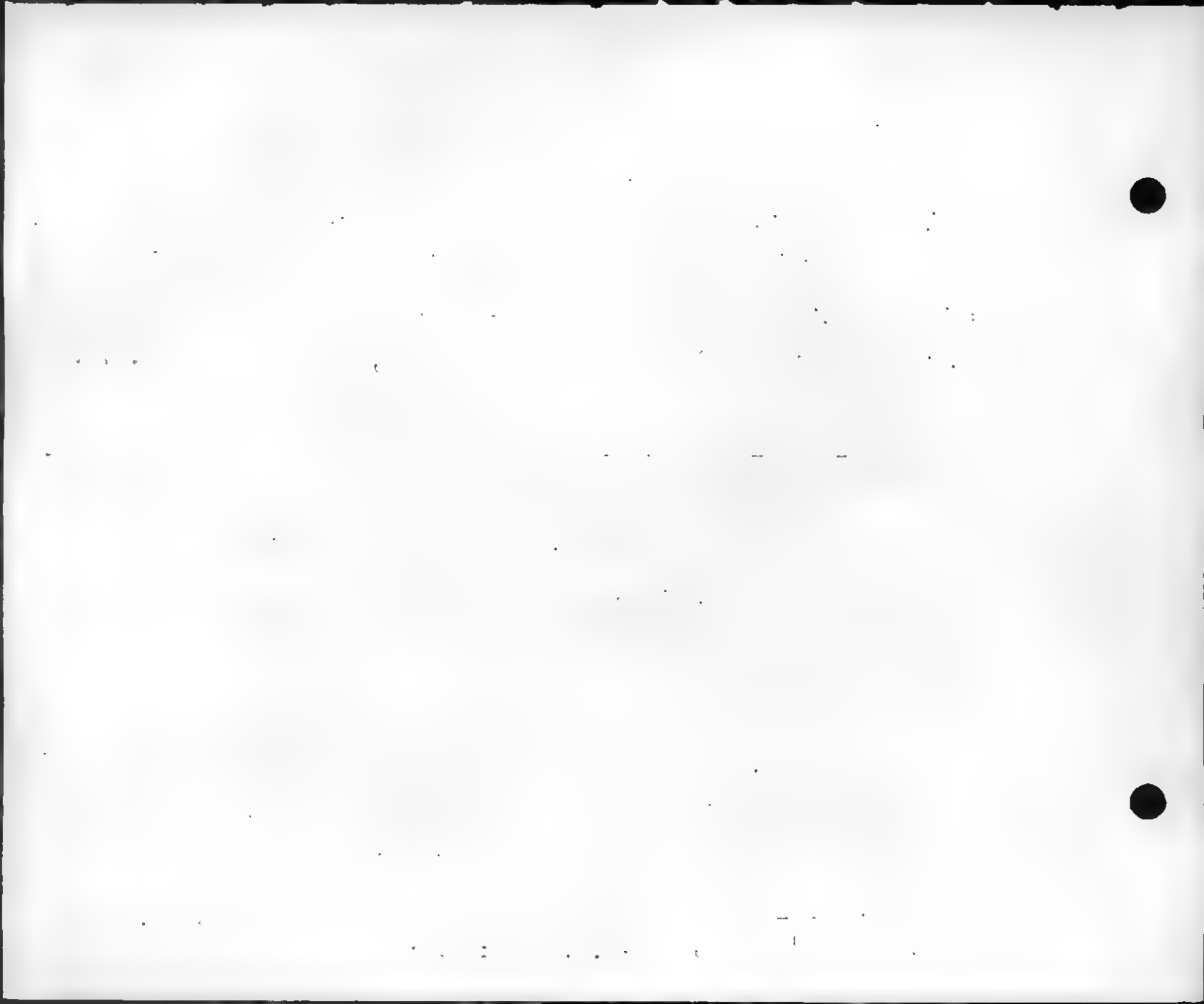


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BP

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4114 Warner Street</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>4114 Warner Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>RUDY JOHN MIHALICK</b> First Middle Last					4. DATE OF DEATH <b>February 1 19 66</b> Month Day Year				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-7-1898</b>		9. AGE (In years last birthday) <b>67</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bricklayer (Retired)</b>					10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <b>Budapest, Hungary</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>Unknown</b>					14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>578-03-4606</b>		17. INFORMANT <b>Herma Mihalick (Wife)</b> See Item #2. Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>									INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b> <b>Known</b> <b>2 years</b> <b>Unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Feb 11</b> , 1964, to <b>Feb 1</b> , 1966, that (I) (we) last saw the deceased alive on <b>Dec 23</b> , 1965, and that death occurred at <b>M</b> , from the causes and on the date stated above.									
22a. SIGNATURE <b>Clayton A. Traumm</b>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED <b>Feb 1, 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Joseph Gawler's Sons, Inc.</b>					22d. ADDRESS <b>8237 Georgia Ave - Silver Spring Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation 2-2-1966</b>			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION (City, town or county) (State) <b>Suitland Md.</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>					25a. REC'D BY REGISTRAR <b>WASH. DC. FEB 8 1966</b>				
					25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 72 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

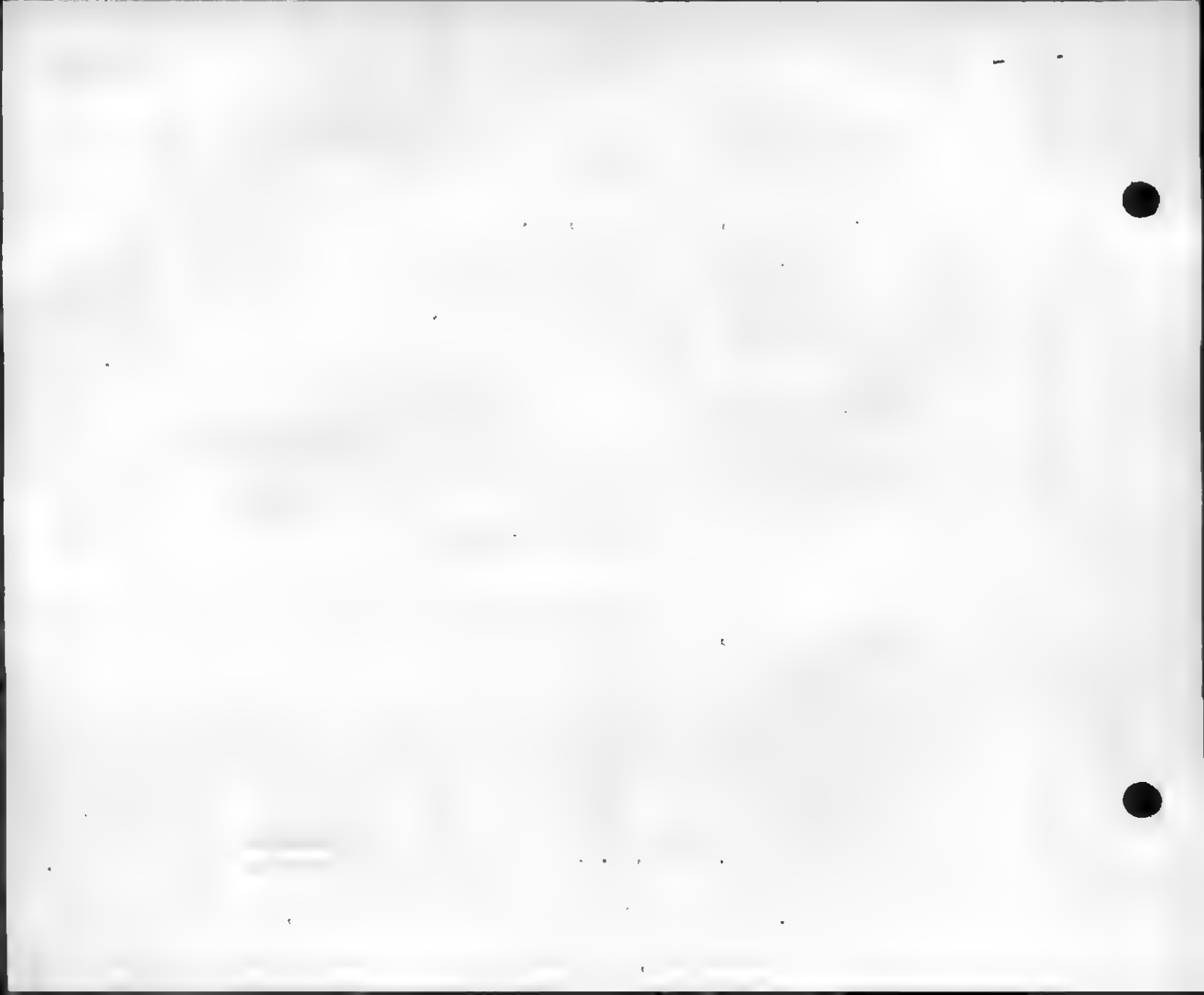
## CERTIFICATE OF DEATH

02559

02524

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>64 days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Md.</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Shanks</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(No street address)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Robert Lee Montgomery</b>			4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>1966</b>				
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 14, 1954</b>	9. AGE (In years last birthday) <b>11</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>12</b> Hours <b>19</b> Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			
13. FATHER'S NAME <b>Santford B. Montgomery</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Record</b> <b>The Clinical Center, Bethesda 14, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gram Negative Sepsis</b> DUE TO (b) <b>Acute Myelogenous Leukemia</b> DUE TO (c) <b>Hepatic failure, 10 days; Renal failure, 3 days</b>					INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b> <b>2 years</b>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 10, 1965</b> , to <b>February 12, 1966</b> , that (we) last saw the deceased alive on <b>February 12, 1966</b> , and that death occurred at <b>3:42M</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Robert C. Gallo</b>				22b. DATE SIGNED <b>12 February 1966</b>			
22c. PHYSICIAN'S NAME (Type) <b>Robert C. Gallo, M.D.</b>				22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Feb. 15, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Hott's Chapel</b>			
23d. LOCATION (City, town or county) <b>Kirby, West Virginia</b>		23e. (State) <b>West Virginia</b>		23f. (Country) <b>U.S.A.</b>			
24. FUNERAL DIRECTOR <b>Tyson Wheeler</b> <b>1331 Rockville Pike</b> <b>Rockville, Maryland</b>				25a. REC'D BY REGISTRAR <b>FEB 16 1966</b> DATE			
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							

MEDICAL CERTIFICATION





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

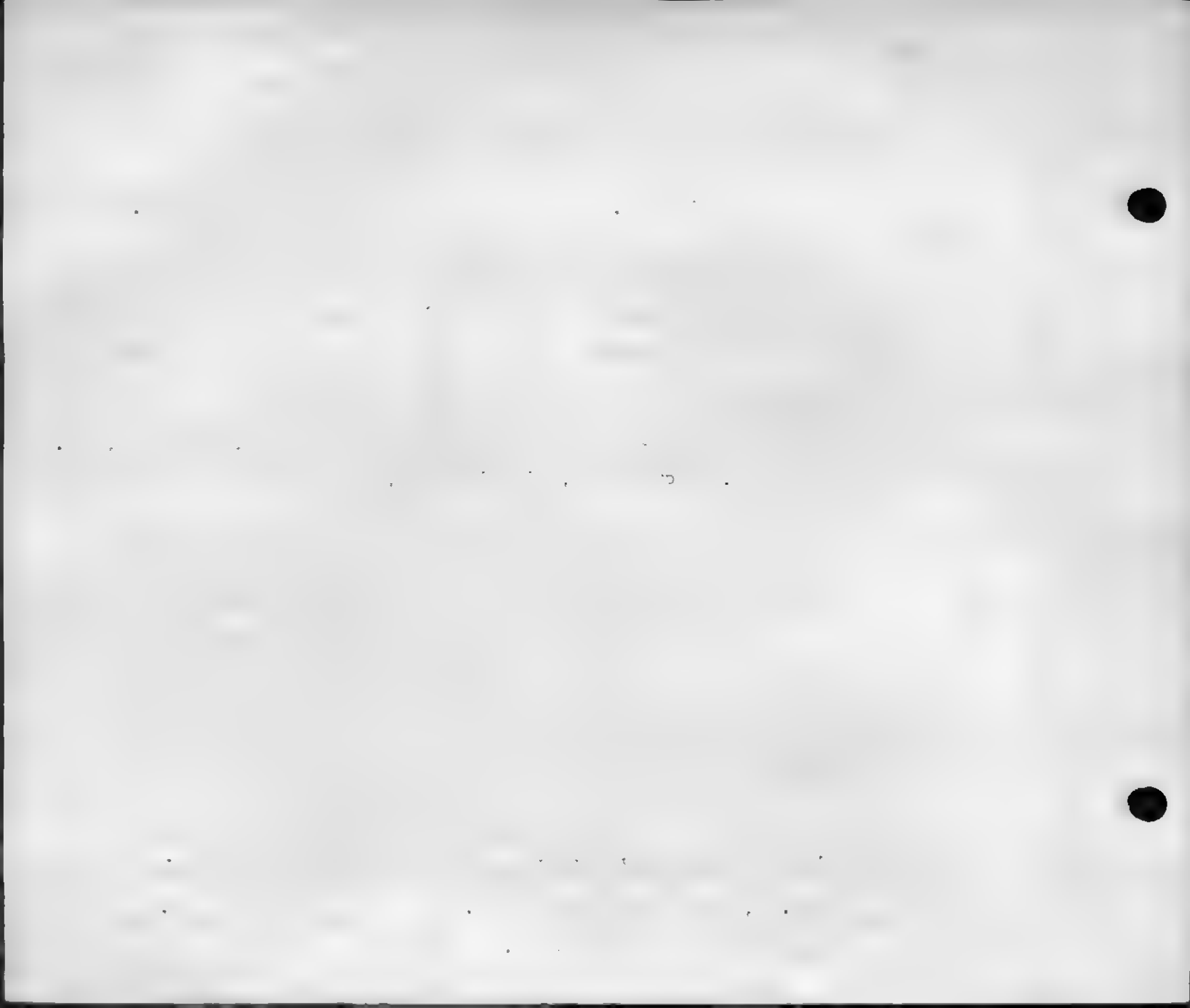
## CERTIFICATE OF DEATH

02560

02525

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;"><u>MARYLAND</u></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>9510 Pleasant Plains Rd.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Damascus</u> d. STREET ADDRESS <u>9510 Pleasant Plains Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Pearl</u> Middle <u>Estelle</u> Last <u>Moore</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>4</u> Year <u>1966</u>		<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>Dec. 26, 1889</u>		<b>9. AGE</b> (In years last birthday) <u>76</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Damascus, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Levi W. Pearce</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Marian Jones</u>							
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>				<b>16. SOCIAL SECURITY NO.</b> <u>--</u>		<b>17. INFORMANT</b> <u>Mrs Herman W. Mullinix, Damascus, Md.</u>		Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma, Sigmoid Colon,</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>1523</u> (a), stating the underlying cause last. } DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>Surgery</u> <u>10/20/64</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>										<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>No Injury</u>							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>  </u> a.m. <u>  </u> p.m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b>		(County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>October</u> <u>1964</u> , to <u>February 4</u> <u>1966</u> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <u>February 4, 1966</u> , and that death occurred at <u>1</u> P.M. from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>M. McKendree Boyer, M.D.</u>				<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>2/5/66</u>					
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>M. McKendree Boyer, M. D.</u>				<b>22d. ADDRESS</b> <u>9701 Church Street</u> <u>Damascus, Maryland.</u>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>Feb. 7, 1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Damascus Meth.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Damascus, Md.</u>					
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John L. H. [Signature]</u>				ADDRESS <u>Damascus, Md.</u>		<b>25a. REC'D BY REGISTRAR</b> DATE <u>FEB 9</u> <u>1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>[Signature]</u>			



2/17 Cleared with Dr. Boldon Hoop - Medical Examiner's Office - Md.

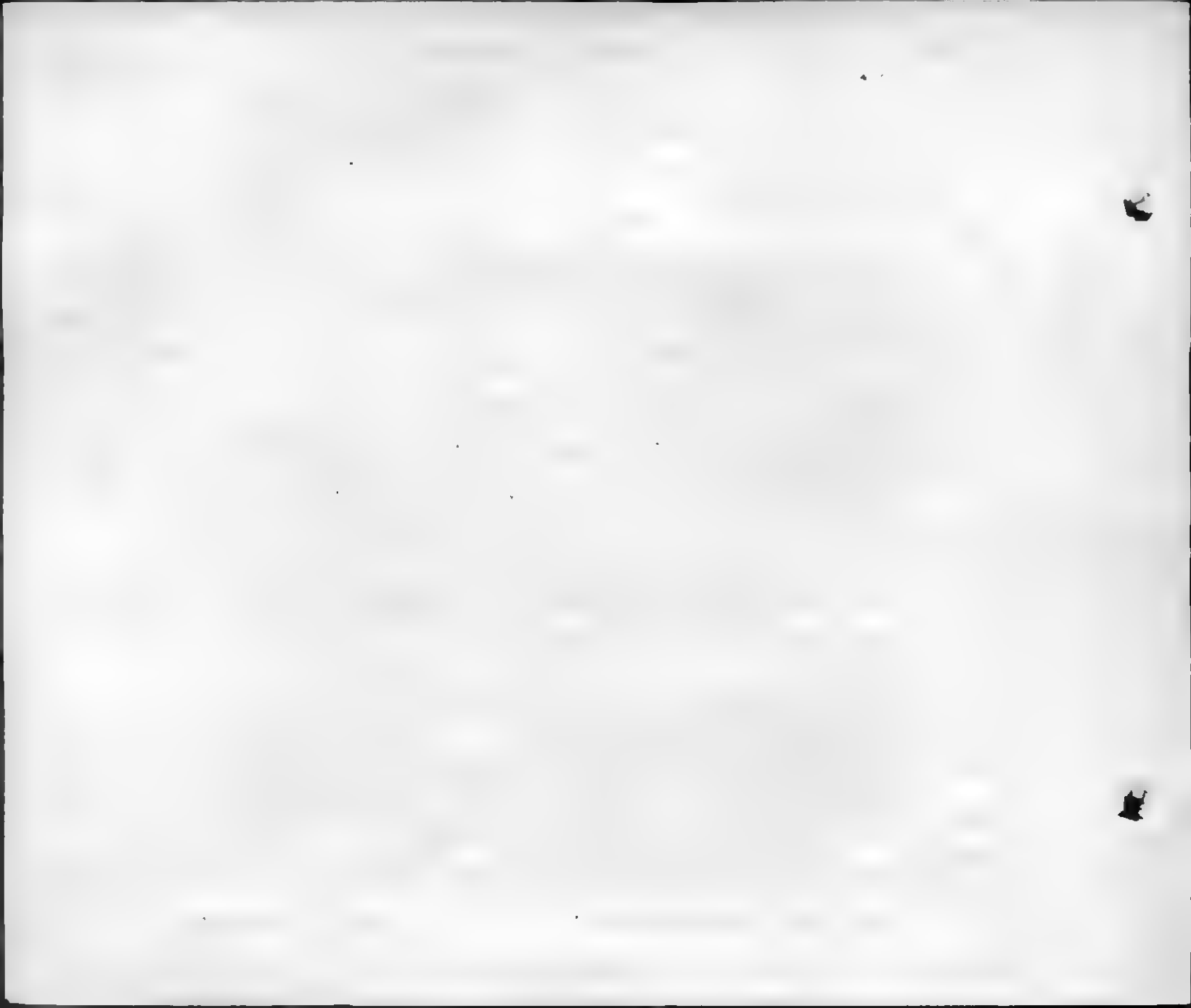
# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

02561

Reg. Dist. No. 02526

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lakoma Park</b>				c. LENGTH OF STAY IN 15			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Washington Sanatorium</b>				d. STREET ADDRESS <b>9815 East Light Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Bernard</b> Middle <b>Morse</b> Last <b>Morse</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>17</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1885</b>	9. AGE (in years last birthday) yrs. <b>80</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min <b></b>	IF UNDER 24 HRS. Hours <b></b> Min <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shoe Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Shoe</b>		11. BIRTHPLACE (State or foreign country) <b>Russia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>013-09-8977</b>		17. INFORMANT Address <b>Arthur I. Morse, Son; same as 2 above</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b></b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>Feb 17, 1966</b> to <b>Feb 17, 1966</b> , that I last saw the deceased alive on <b>Feb 17, 1966</b> , and that death occurred at <b>3:20 P.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Sydney Leventhal, M.D.</b>				ADDRESS (Street, city or town, state) <b>9710 Cobsville Rd., Silver Spring, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Sydney Leventhal, M.D.</b>				DATE SIGNED <b>2/17/66</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-18-1966</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Hyattsville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hardberg Funeral Home</b>				ADDRESS <b>4217-9th St N.W.</b>		24a. REC'D BY REGISTRAR <b>FEB 21 1966</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

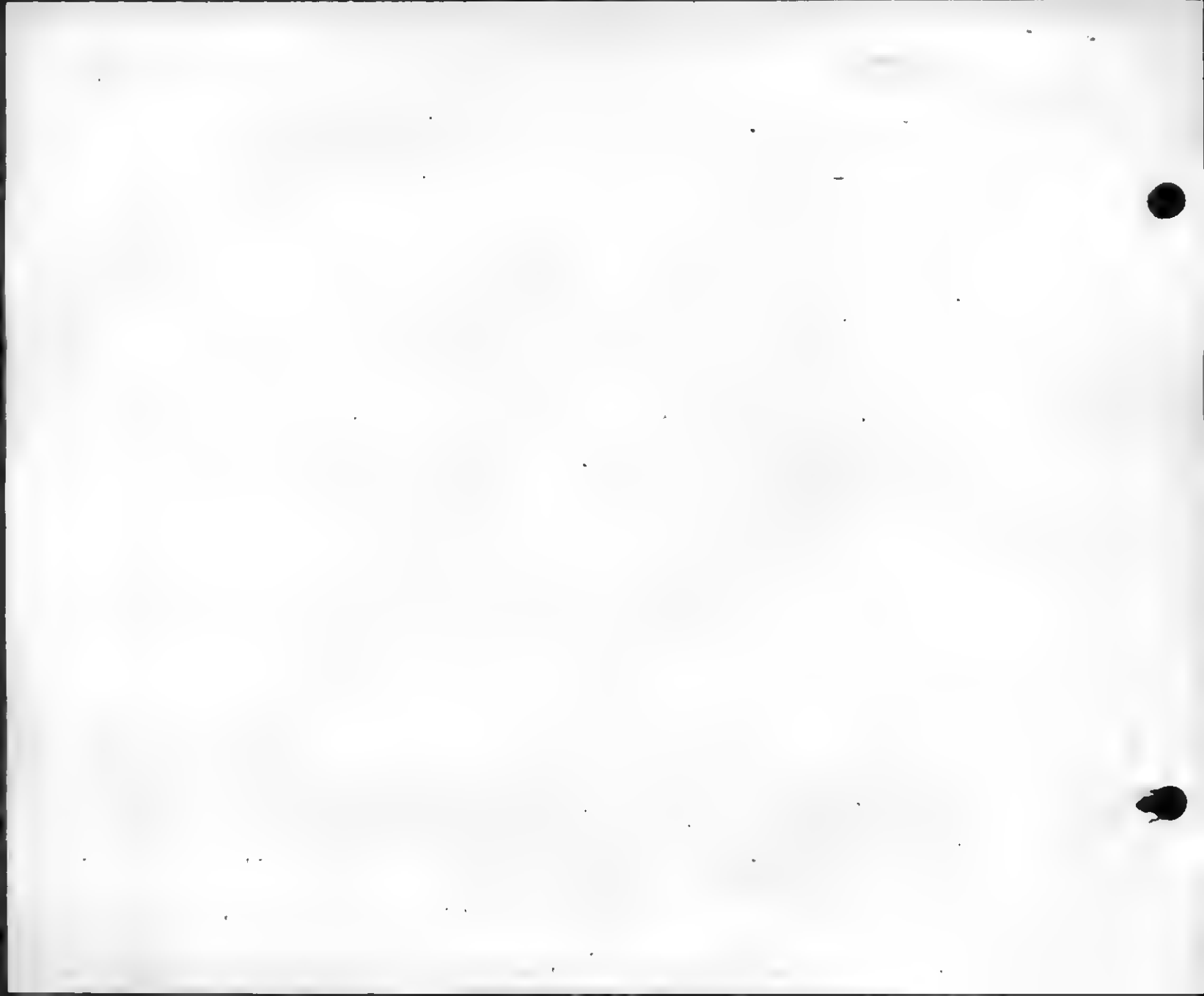
## CERTIFICATE OF DEATH

02562

02527

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15 days</u>	
d. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>525 Cace Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Jeanne L Moscrush</u>		4. DATE OF DEATH <u>Feb 22 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/1925</u>
9. AGE (n years last birthday) <u>40</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Saleswoman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Colony Shop</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Shipp, R. E. P. 222</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Arthur Cooper</u>		14. MOTHER'S MAIDEN NAME <u>Clara Dickson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <u>15920 0711</u>	
17. INFORMANT <u>W. J. Moscrush - 7720</u>		Address <u>7720</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> DUE TO (b) <u>1-1X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>1-1X</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 18</u> , 19 <u>66</u> , to <u>Feb 22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 21</u> , 19 <u>66</u> , and that death occurred at <u>9:20</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED <u>2-22-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>		22d. ADDRESS <u>7720 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2/25/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>FEB 24 1966</u>	
ADDRESS <u>1331 Rockville Pike Rockville, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it is completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02553

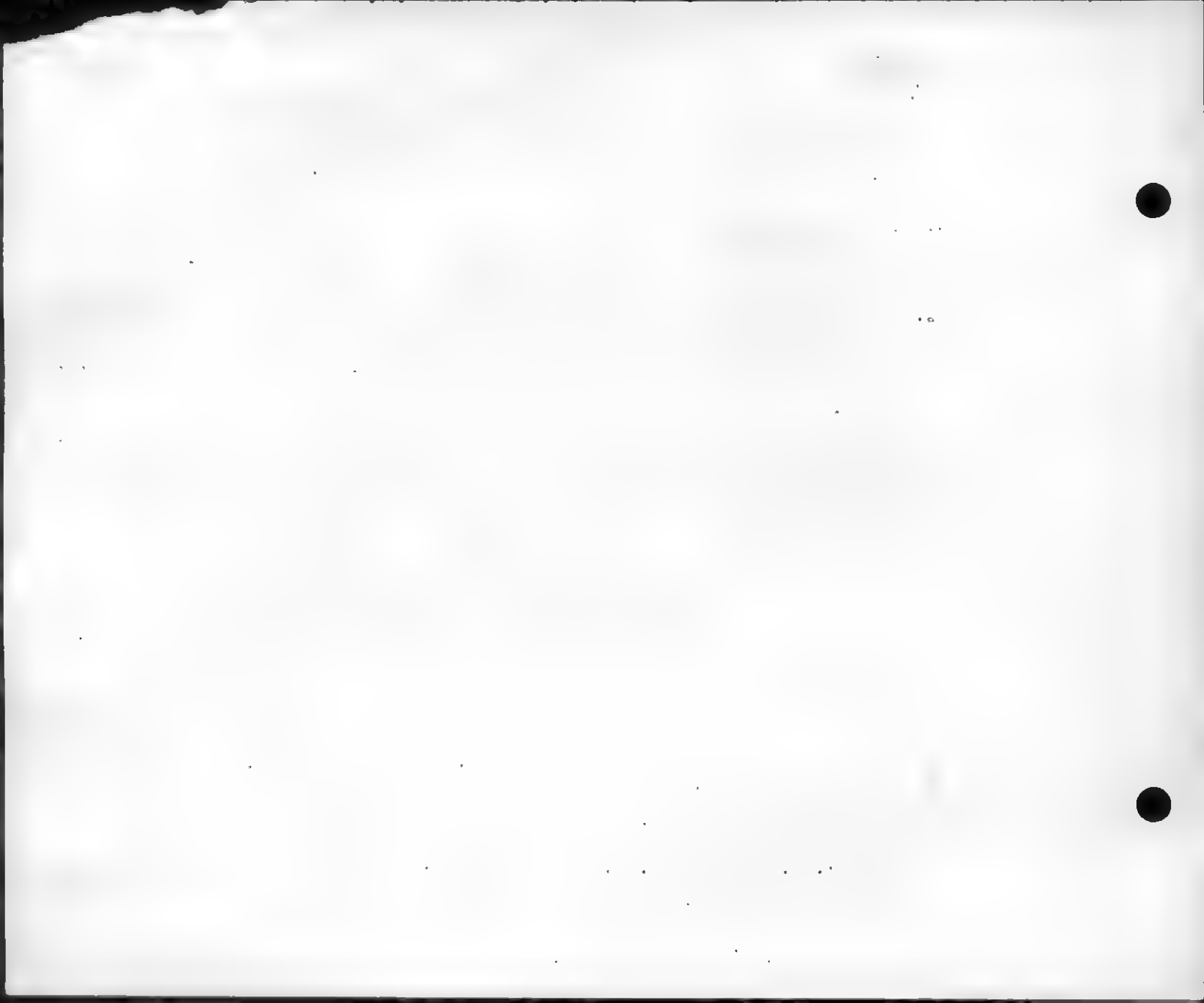
CERTIFICATE OF DEATH

02528

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY in lb <b>36 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Springfield</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>				d. STREET ADDRESS <b>8121 Greeley Blvd.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary Ellen MUROS</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>9</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 25, 1931</b>	9. AGE (In years last birthday) <b>34</b> yrs	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>		IF UNDER 24 HRS Hours <b>0</b> Min <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of waking life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Alexandria, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Warren M. Gettle</b>				14. MOTHER'S MAIDEN NAME <b>Hilda V. Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO		17. INFORMANT <b>Springfield, Va. Ralph L. Muros, 8121 Greeley Blvd., West/</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanoma, malignant</b> <b>1909</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <b>Jan. 4</b> , 19 <b>66</b> , to <b>Feb. 9</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>Feb. 9</b> , 19 <b>66</b> , and that death occurred at <b>1201 M</b> from causes and on the date stated above							
22a. SIGNATURE <b>F. C. Johnson</b>				22b. DATE SIGNED <b>Feb. 9, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>F. C. Johnson, M. D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>2-11-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or town) (County) (State) <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Everly &amp; Wheatley, 1500 Braddock Rd.</b>				25a. REC'D BY REGISTRAR <b>Feb 11 1966</b>		25b. REGISTRAR'S SIGNATURE <b>John Charles Judge</b>	
26. ADDRESS <b>Alexandria, Va.</b>							





# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

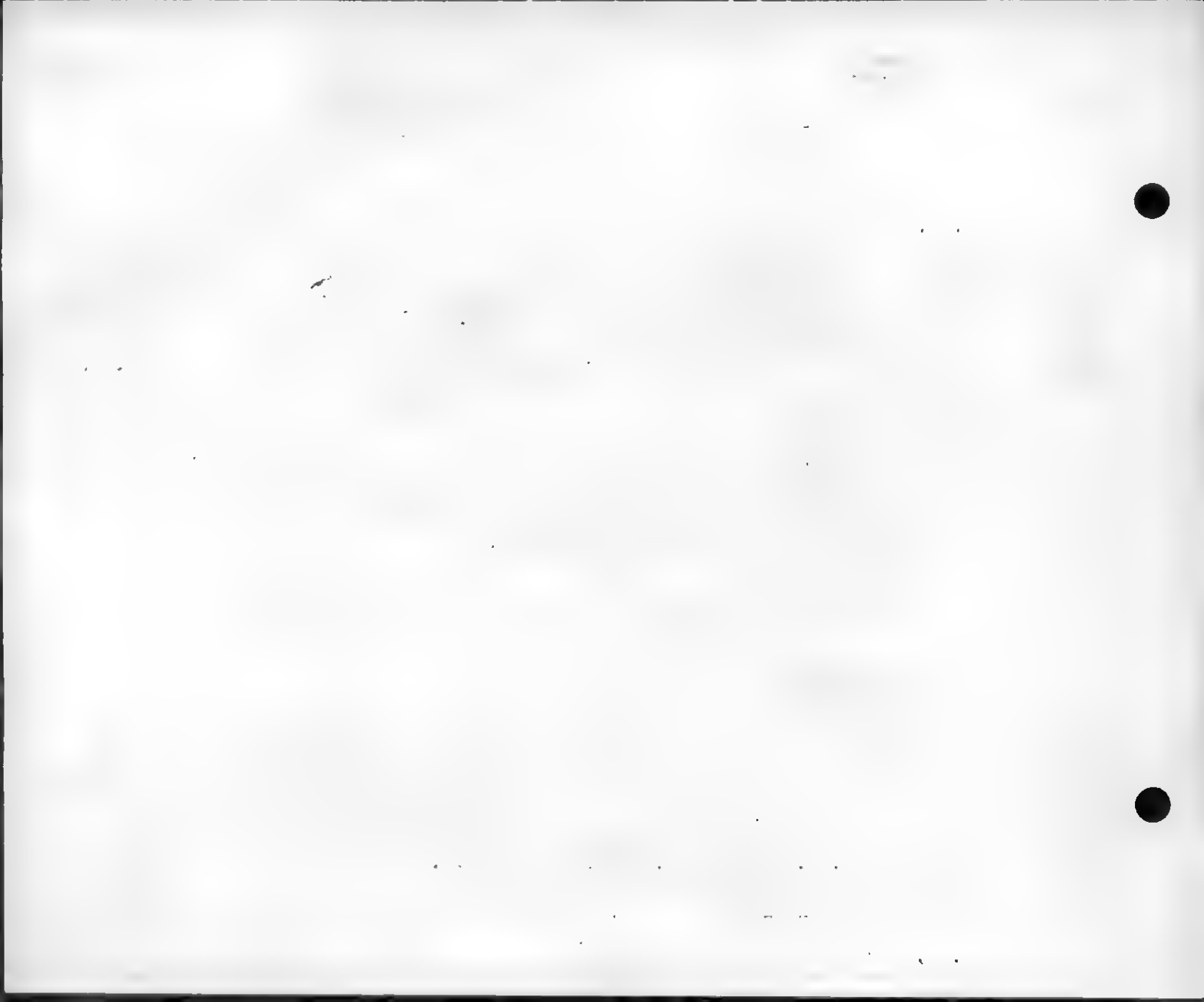
02564

## CERTIFICATE OF DEATH

02529

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY in 1b <b>2 days</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U. S. Naval Hospital</b>			d. STREET ADDRESS <b>13020 Turkey Branch Parkway</b>		e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First <b>Elizabeth</b> (N) Middle <b>Murray</b> Last			4 DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1966</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1880</b>	9. AGE (In years last birthday) <b>85 yrs</b>	10. F UNDER 1 YEAR Months <b>10</b> Days <b>10</b> Hours <b>10</b> Min <b>10</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Pomonkey Maryland</b>	
13. FATHER'S NAME <b>Richard Crooke</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>None</b>		17. INFORMANT <b>Edwin Murray Lanham, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hematoma</b> DUE TO (b) <b>Arterial hypertension</b> DUE TO (c) <b>20 yrs.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8 February, 1966</b> , to <b>10 February 1966</b> , that (I) (we) last saw the deceased alive on <b>10 February 1966</b> , and that death occurred at <b>6 P.M.</b> from causes and on the date stated above					
22a. SIGNATURE <b>W. L. Brannon Jr.</b>			22b. DATE SIGNED <b>11 February 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>W. L. Brannon Jr. LT MC USN</b>
22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>2-14-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg Maryland</b>	
24. FUNERAL DIRECTOR'S NAME (Type) <b>W. E. Pumphrey Silver Spring, Maryland</b>			25a. REC'D BY REGISTRAR <b>FEB 16 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02553 CERTIFICATE OF DEATH 02531											
1. PLACE OF DEATH a. COUNTY Montgomery county b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kensington c. LENGTH OF STAY IN b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Hall Sanitarium						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE District of Columbia b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington d. STREET ADDRESS 4500 Conn Ave NW. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ELIZABETH			First Middle Last NEWBURN			4. DATE OF DEATH FEBRUARY 15 1966			Month Day Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-1894		9. AGE (in years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Homemaker		11. BIRTHPLACE (County & State, or foreign country) Lincoln, New York			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME KERN						14. MOTHER'S MAIDEN NAME UNKNOWN					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 579-66-8157		17. INFORMANT Mrs. E.G. Weiss, Same as 2d Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA (LEFT BREAST) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) SENILITY INTERVAL BETWEEN ONSET AND DEATH 13 MO.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-2, 1962, to FEB. 15, 1966, that (I) (we) last saw the deceased alive on FEB 15 1966, and that death occurred at 2:10 M, from the causes and on the date stated above.											
22a. SIGNATURE Henry Louden						22b. DATE SIGNED 2/15/66					
22c. PHYSICIAN'S NAME (Type) Lee Crematory						22d. ADDRESS 5206 NORWAY DR CHICO CHASE, MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation				23b. DATE THEREOF Feb 16, 66		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION (City, town or county) (State) Washington DC			
24. FUNERAL DIRECTOR Lee Funeral Home, 300 4th St, NE Wash DC						25a. REC'D BY REGISTRAR FEB 13 1966			25b. REGISTRAR'S SIGNATURE J. M. Judge		

MEDICAL CERTIFICATION



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02566

## CERTIFICATE OF DEATH

02531

1 PLACE OF DEATH COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write BORO. and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>30 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>209 Lees St</u>	
3 NAME OF DECEASED (Type or print) <u>Thomas Clint Nichols</u>		4 DATE OF DEATH <u>2-6</u> 19 <u>66</u>	
5 SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7-31</u> 19 <u>34</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Starch, Capital City, Inc.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11 BIRTHPLACE (County & State, or foreign country) <u>MD</u>		12 CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13 FATHER'S NAME <u>U. Lynn H. Nichols</u>		14 MOTHER'S MAIDEN NAME <u>Marie Bennett</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>None</u>		16 SOCIAL SECURITY NO <u>None</u>	
17 INFORMANT <u>Marie Nichols</u>		Address <u>mother</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5810</u> DUE TO <u>Cerebral Thrombosis of the Riner</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u></u> (c) DUE TO <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>Years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic pancreatitis</u>			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1/7/66</u> , 19 <u>66</u> , to <u>2/5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2/5</u> , 19 <u>66</u> , and that death occurred at <u>3:15</u> P.M., from causes and on the date stated above.			
22a. SIGNATURE <u>Fredrick Y. Donahoe</u> M.D.		22b. DATE SIGNED <u>2/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FREDERICK Y. DONAHOE</u>		22d. ADDRESS <u>Perkins Dr., Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>2-9-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Darnestown Presbyterian Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Darnestown, Md.</u>
24. FUNERAL DIRECTOR <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>8434 Rockville Avenue Silver Spring, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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5M 1/63

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>MARYLAND</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. STREET ADDRESS <b>1028 University Blvd. East #913</b>	
3. NAME OF DECEASED (Type or print) <b>Emil Oettinger</b>		4. DATE OF DEATH <b>Feb. 25 19 66</b>		5. SEX <b>Male</b>	
6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/28/1901</b>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Insurance Broker</b>		9b. KIND OF BUSINESS OR INDUSTRY <b>Insurance</b>		9c. AGE (In years last birthday) <b>64</b>	
10a. BIRTHPLACE (State or foreign country) <b>Bavaria, Germany</b>		10b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. FATHER'S NAME <b>Sally Oettinger</b>	
12. MOTHER'S MAIDEN NAME <b>Dolce Ullmann</b>		13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		14. SOCIAL SECURITY NO. <b>1028 University Blvd. Silver Spring, Md.</b>	
15. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO <b>Coronary Artery Heart Disease</b> DUE TO <b>Coronary Artery Heart Disease</b>		16. INTERVAL BETWEEN ONSET AND DEATH <b>4201</b>		17. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>	
18a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
19a. TIME OF INJURY Month, Day, Year <b>19 66</b>		19b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20a. (City or town) <b>Hyattsville</b>		20b. (County) <b>MD.</b>		20c. (State) <b>MD.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. CHIEF MEDICAL EXAMINER <b>Belden R. Reap</b>		23. ASSISTANT MEDICAL EXAMINER <b>W. H. Whitson</b>	
24. ACTUAL SIGNATURE <b>BELDEN R. REAP, M.D.</b>		25. DATE SIGNED <b>Feb. 26, 1966</b>		26. DEPUTY MEDICAL EXAMINER <b>Charles Judge</b>	
27. EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		28. ADDRESS (Street, City, Town, or County) <b>3591 14th St. N.W. Wash. D.C.</b>		29. LOCATION (City, town, or county) <b>Hyattsville MD.</b>	
30. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		31. DATE THEREOF <b>FEB 27, 1966</b>		32. NAME OF CEMETERY OR CREMATORY <b>MT. LEBANON CEMETERY</b>	
33. FUNERAL DIRECTOR <b>B. DANZANSKY + SONS</b>		34. REC'D BY REGISTRAR <b>MAR 2 1966</b>		35. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	





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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
02558											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN ID <u>2yrs-7months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>10418 Royal Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Morris</u> Middle <u>Ohlbaum</u> Last <u>Ohlbaum</u> 4. DATE OF DEATH Month <u>2</u> - Day <u>1</u> Year <u>1966</u>						5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>4-18-72</u> 9. AGE (In years last birthday) <u>93</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Garage Owner</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>Hungary</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>						13. FATHER'S NAME <u>Solomon Ohlbaum</u> 14. MOTHER'S MAIDEN NAME <u>Unknown</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Stanley H. Ohlbaum - 10418 Royal Rd Silver Spring Md</u> Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 412X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Cerebral Arteriosclerosis, Probable Ca Prostate</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>Jul</u> , 19 <u>63</u> , to <u>2/1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1/27</u> , 19 <u>66</u> , and that death occurred at <u>9P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Ira N. Tublin</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>IRA N. Tublin</u> 22d. ADDRESS <u>25 E. Wayne Ave. S.S. Md</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2/3/66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>mt. Hebron Cemetery</u> 23d. LOCATION (City, town, or county) (State) <u>New York, N.Y.</u>											
24. FUNERAL DIRECTOR <u>B. Donzansky &amp; Sons</u> ADDRESS <u>3501-14th St N.W. Wash DC</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE DATE <u>B 7 1966</u>											



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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

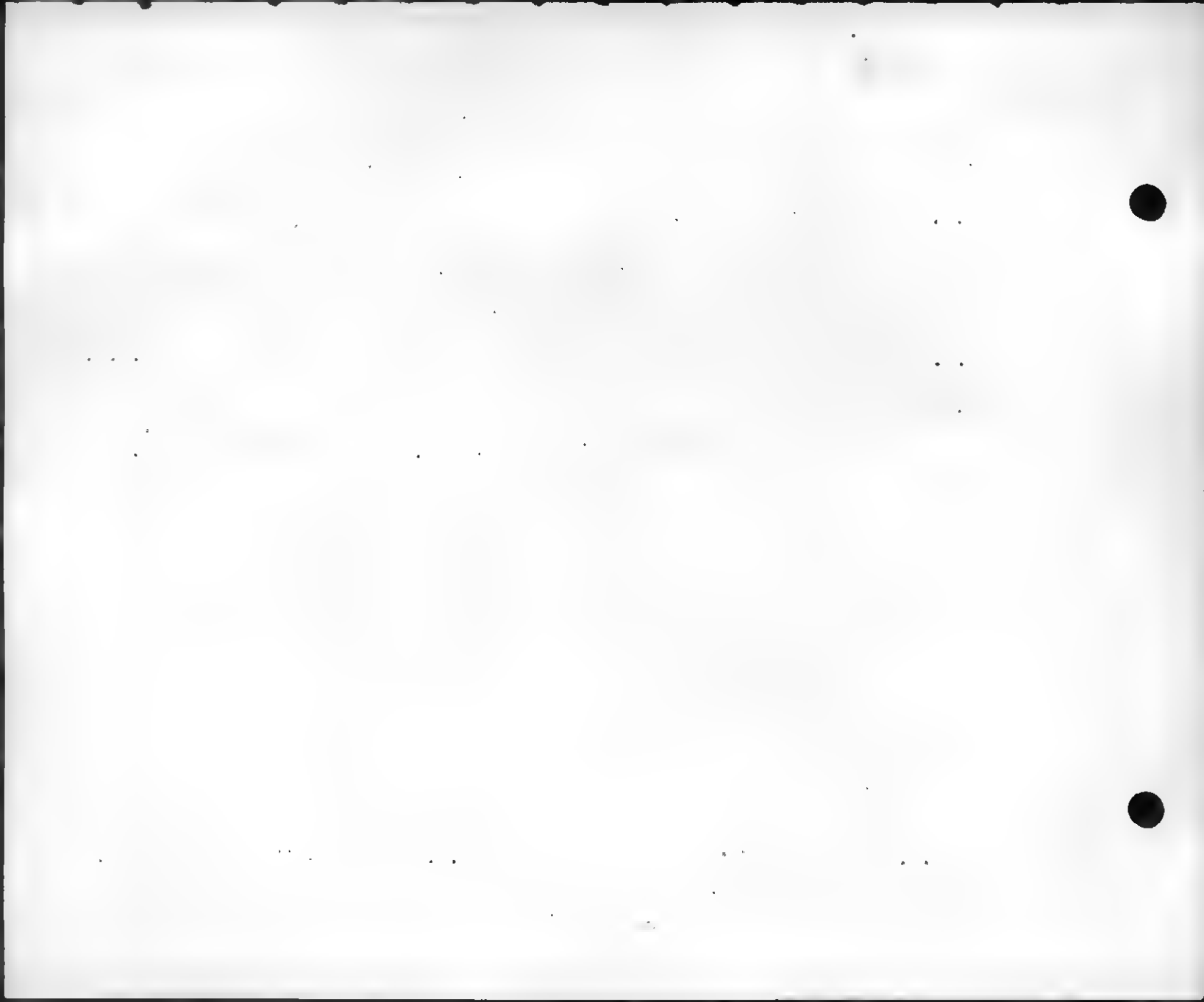
02539

## CERTIFICATE OF DEATH

Item #9 Film #0373 2/11/66

02534

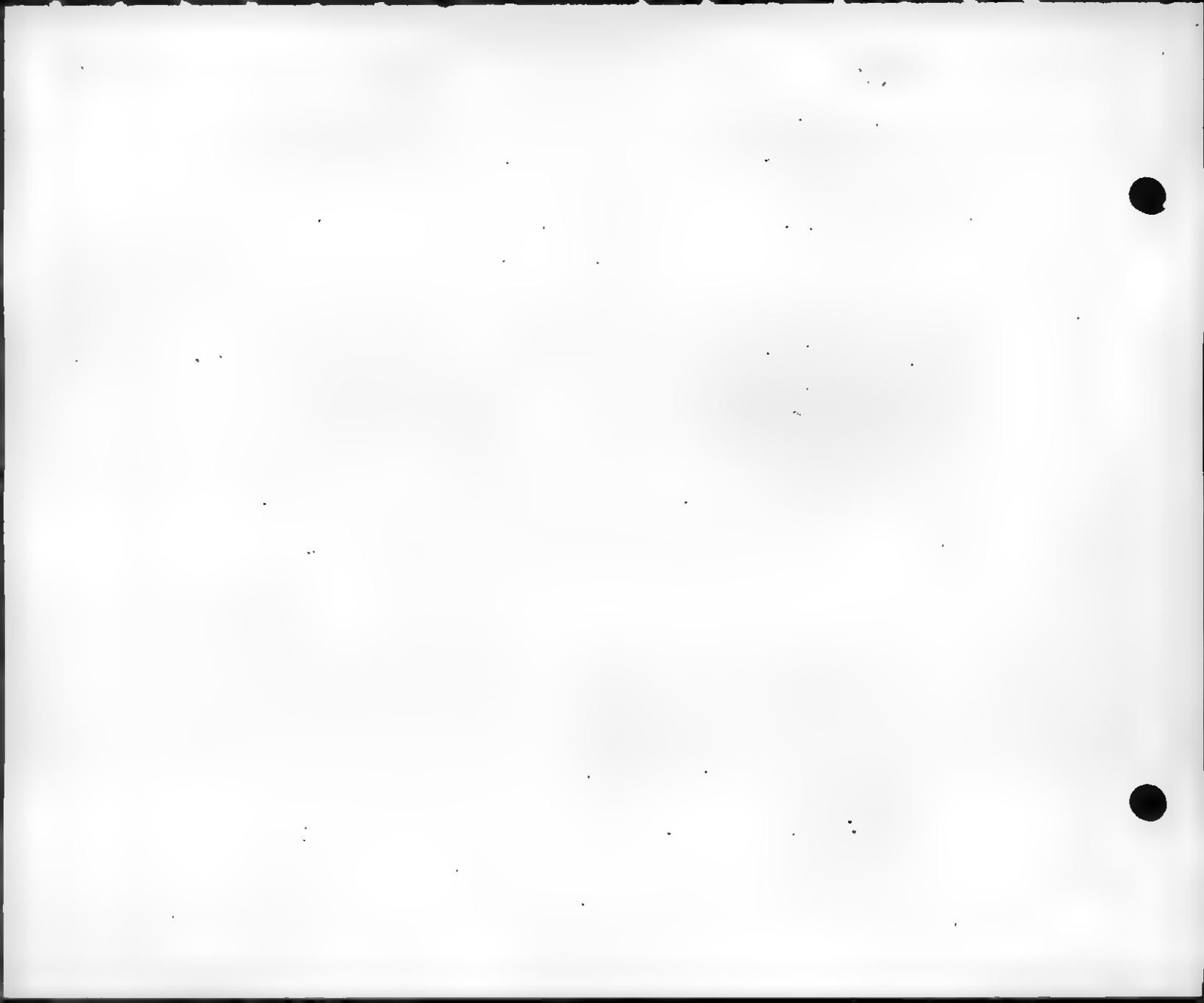
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>				c. LENGTH OF STAY IN ID <b>214 days</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Virginia</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield</b>				d. STREET ADDRESS <b>7421 Farnum Street</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) <b>Leonard Joseph Opeil</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1966</b>				5. SEX <b>Male</b>				6. COLOR OR RACE <b>Cauc</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH <b>December 5 1917</b>				9. AGE (In years last birthday) <b>48 yrs.</b>				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. Navy</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Ohio</b>				11. BIRTHPLACE (County & State, or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Martin Opeil</b>				14. MOTHER'S MAIDEN NAME <b>Mary Benner</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>ACTIVE DUTY 281-14-1428</b>				17. INFORMANT <b>Susan E. Opeil</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignant Lymphoma</b> 2002 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. OUE TO (b) OUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)															
21. I certify that (this hospital) attended the deceased from <b>July 1965</b> , to <b>Feb 1966</b> , that (we) last saw the deceased alive on <b>Feb 1966</b> , and that death occurred at <b>4:35 PM</b> , from the causes and on the date stated above.				22a. SIGNATURE <b>R.B. Moquin</b>				22b. DATE SIGNED <b>5 February 1966</b>				22c. PHYSICIAN'S NAME (Type) <b>R.B. Moquin LCDR MC USN</b>				22d. ADDRESS <b>U.S. Naval Hospital Bethesda Md.</b>				22e. REC'D BY REGISTRAR <b>W.W. CHAMBERS</b>				22f. REGISTRAR'S SIGNATURE <b>WASHINGTON DC</b>																			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>				23b. DATE THEREOF <b>2/9/66</b>				23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON MTH</b>				23d. LOCATION (City, town or county) (State) <b>ARLINGTON VA.</b>				24. FUNERAL DIRECTOR <b>W.W. CHAMBERS</b>				25a. REC'D BY REGISTRAR <b>WASHINGTON DC</b>				25b. REGISTRAR'S SIGNATURE <b>Feb 9 1966</b>																			



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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Thomas Park</u> c. LENGTH OF STAY IN 1b <u>13 hrs 40 min</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanatorium &amp; Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Maryland</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Park</u> d. STREET ADDRESS <u>6509 C. St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Lillian Marie Ortman</u> First Middle Last 4. DATE OF DEATH <u>2-23-1966</u> Month Day Year		5. SEX <u>female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-3-06</u> 9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (County & State, or foreign country) <u>District of Columbia</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>William Fitzpatrick</u> 14. MOTHER'S MAIDEN NAME <u>Mary Horner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Hospital Records</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma</u> 112X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of lung</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Dec. 1965</u> to <u>Feb. 23, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb. 22, 1966</u> , and that death occurred at <u>6:15</u> A.M. from the causes and on the date stated above. 22a. SIGNATURE <u>Albert H. Grollman</u> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 22c. PHYSICIAN'S NAME (Type) <u>ALBERT H. GROLLMAN</u> ADDRESS <u>1106 SPRING ST. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>2-26-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>mt Olivet</u> 23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>		24. FUNERAL DIRECTOR <u>See Funeral Home</u> ADDRESS <u>300 4th St. N.E. Wash., D.C.</u> 25a. REC'D BY REGISTRAR <u>FEB 28 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>	



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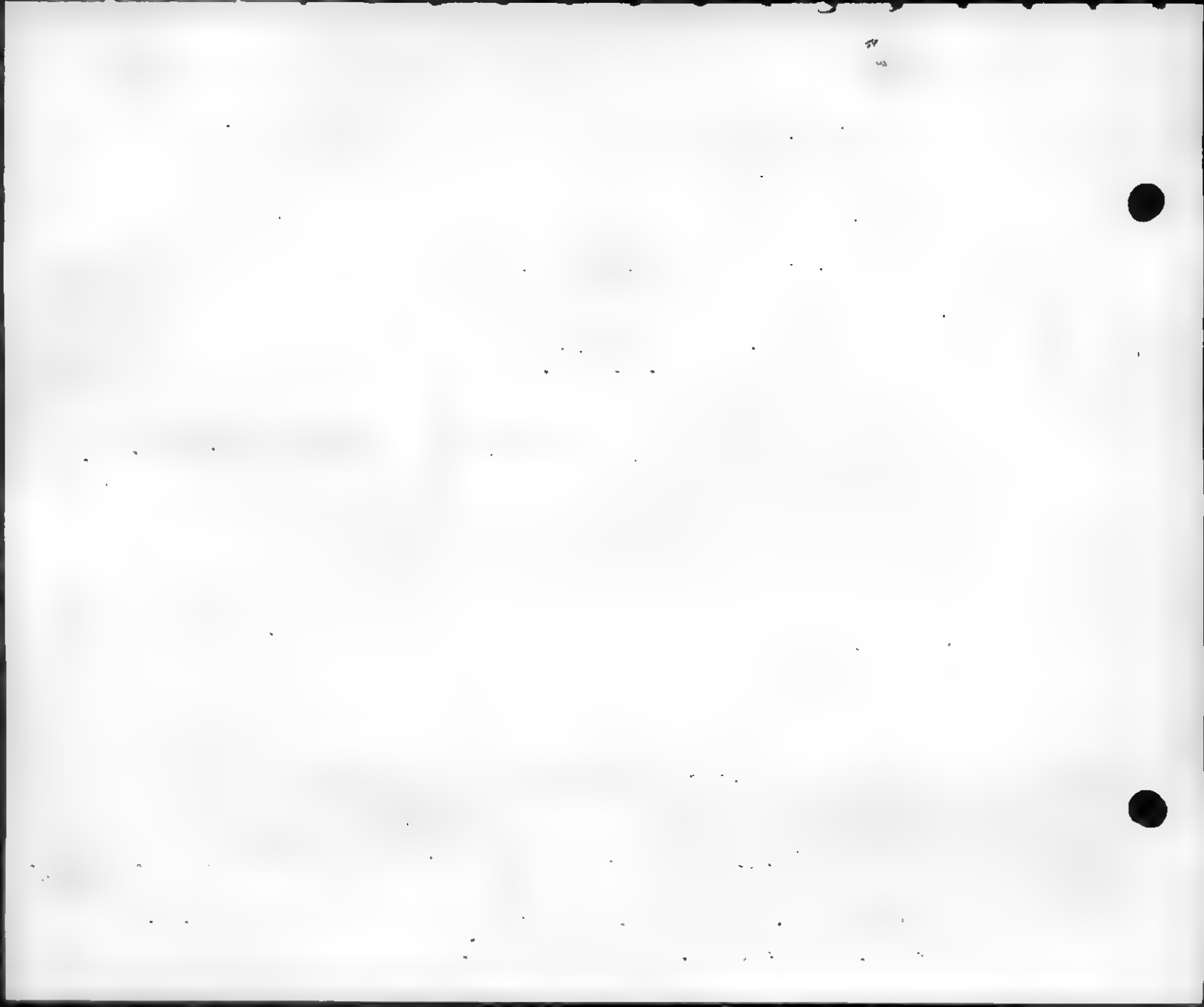
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02571

02536

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u> c. LENGTH OF STAY IN 1b <u>37 1/2 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cherry, Chase</u> d. STREET ADDRESS <u>3616 Spring Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>William Frederick PAHREN</u> First Middle Last				4. DATE OF DEATH Month <u>2</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-19-81</u>	
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerical Head</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>	
12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>				13. FATHER'S NAME <u>August</u>			
14. MOTHER'S MAIDEN NAME <u>NONE RECORDED</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)			
16. SOCIAL SECURITY NO. <u>Unknown</u>				17. INFORMANT <u>Washington Sanitarium and Hospital, Takoma Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post. pneumonia - urinary tract infection</u>				INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>2-24</u> , 19 <u>66</u> , that (I) <del>met</del> last saw the deceased alive on <u>2-24</u> 19 <u>66</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Morrill C. Quinnan</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Morrill C. Quinnan</u>				22d. ADDRESS <u>831 University Blvd., East, Takoma Park, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Feb 25, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington D. C.</u>	
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>				25a. REG'D BY REGISTRAR <u>FEB 28 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. W. Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR 415 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
02572					02537				
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>3 WEEKS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM &amp; Hosp.</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> d. STREET ADDRESS <u>9116 Georgia Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>MONA MARGARET PALMER</u>			First Middle Last		4. DATE OF DEATH <u>FEBRUARY 15 1966</u>		Month Day Year		
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>15 June 1904</u>		9. AGE (in years last birthday) <u>61</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRACTICAL NURSE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ABRAHAM FLINT</u>					14. MOTHER'S MAIDEN NAME <u>Emily Roby</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>212-24-4002</u>		17. INFORMANT <u>Hospital chart</u>		Address <u>WILLIAM SMITH 212-24-4002 SILVER SPRING, MD</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC HEART DISEASE</u> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>GENERALIZED ARTERIOSCLEROSIS</u> DUE TO (c) <u>DIABETES MELLITUS</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u> <u>YEARS</u> <u>YEARS</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-25-</u> , 19 <u>66</u> , to <u>2/15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/15</u> , 19 <u>66</u> , and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>Richard H. Pollen</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/16/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>RICHARD H. POLLEN MD</u>					22d. ADDRESS <u>10511 SUMMIT AVE, KENSINGTON MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>19 Feb 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Maplelawn, XXXXX</u>		23d. LOCATION (City, town or county) (State) <u>Weston, West Virginia</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey, Inc.</u>					ADDRESS <u>8434 Georgia Avenue Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 23 1966</u>		
							25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



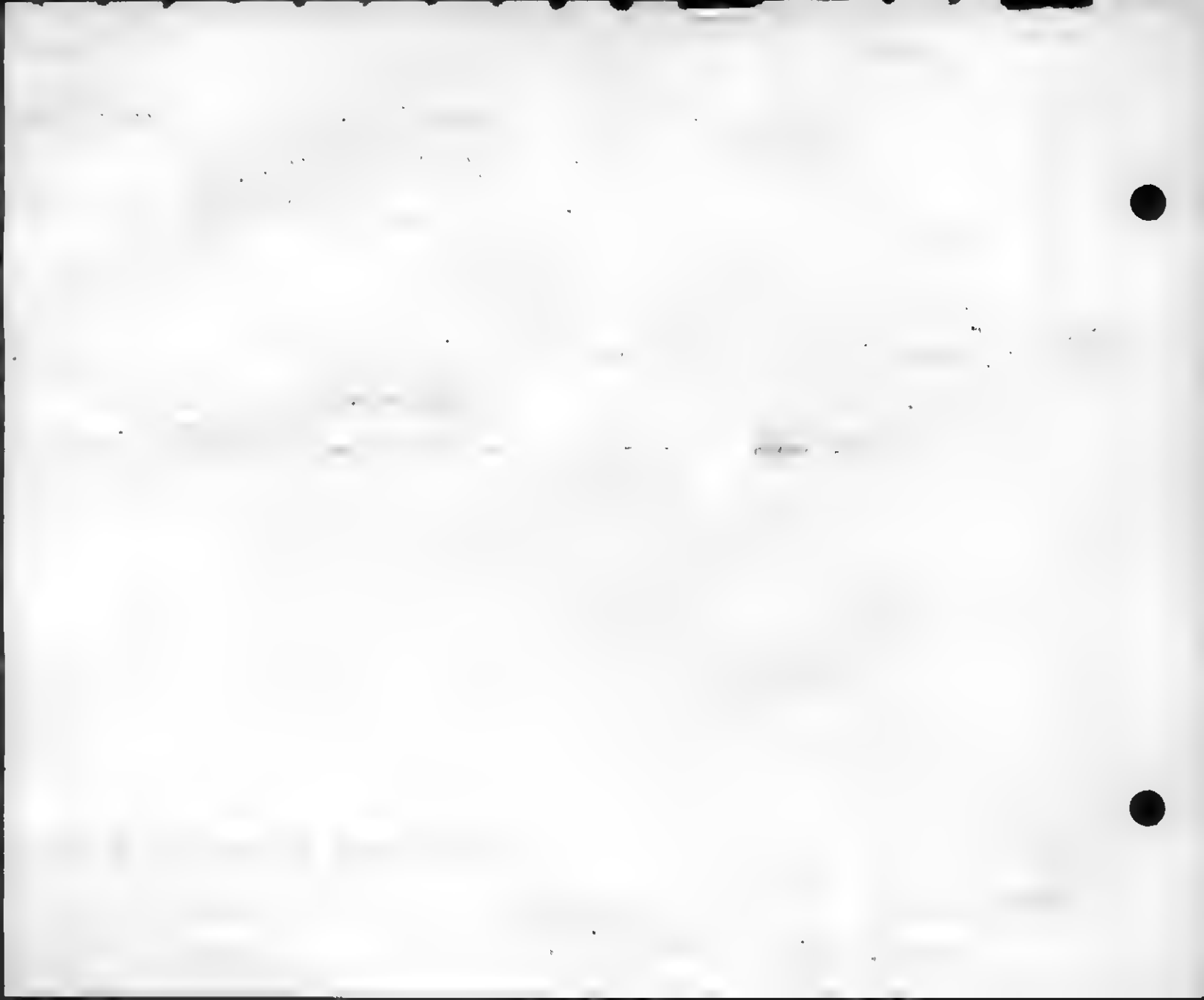
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Classified By Coroner

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
02573 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u> c. LENGTH OF STAY IN 1b <u>3 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HOLY CROSS HOSPITAL-SILVER SPRING</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>New York</u> b. COUNTY <u>Cattaraugus</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WILKINSVILLE</u> d. STREET ADDRESS <u>209 W. Maraine</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>HELEN</u> First Middle Last			4. DATE OF DEATH <u>FEB</u> Month Day Year			5. SEX <u>F</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>1-16-1880</u>			9. AGE (In years last birthday) <u>86</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>			11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>John H. Allen</u>					14. MOTHER'S MAIDEN NAME <u>Rhoda Woodward</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>069-03-9708</u>			17. INFORMANT <u>Mrs. Ruth Stokoe</u> Address <u>9306 Montwood St. Silver Spring, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEBROVASCULAR ACCIDENT</u> 331X DUE TO (b) <u>ARTERIO SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										INTERVAL BETWEEN ONSET AND DEATH <u>13 HRS</u> <u>20 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>2/11</u> , 19 <u>66</u> , to <u>2/14</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>66</u> , and that death occurred at <u>2:20 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Henry W Stout</u>					22b. DATE SIGNED <u>2/14/66</u>						
22c. PHYSICIAN'S NAME (Type) <u>HENRY W STOUT MD</u>					22d. ADDRESS <u>10011 Georgia, Silver Spring, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>Feb 17 1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Souls Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Auburn New York</u>		
24. FUNERAL DIRECTOR <u>Warner E. Pumphrey</u>			25a. REC'D BY REGISTRAR <u>Feb 16 1966</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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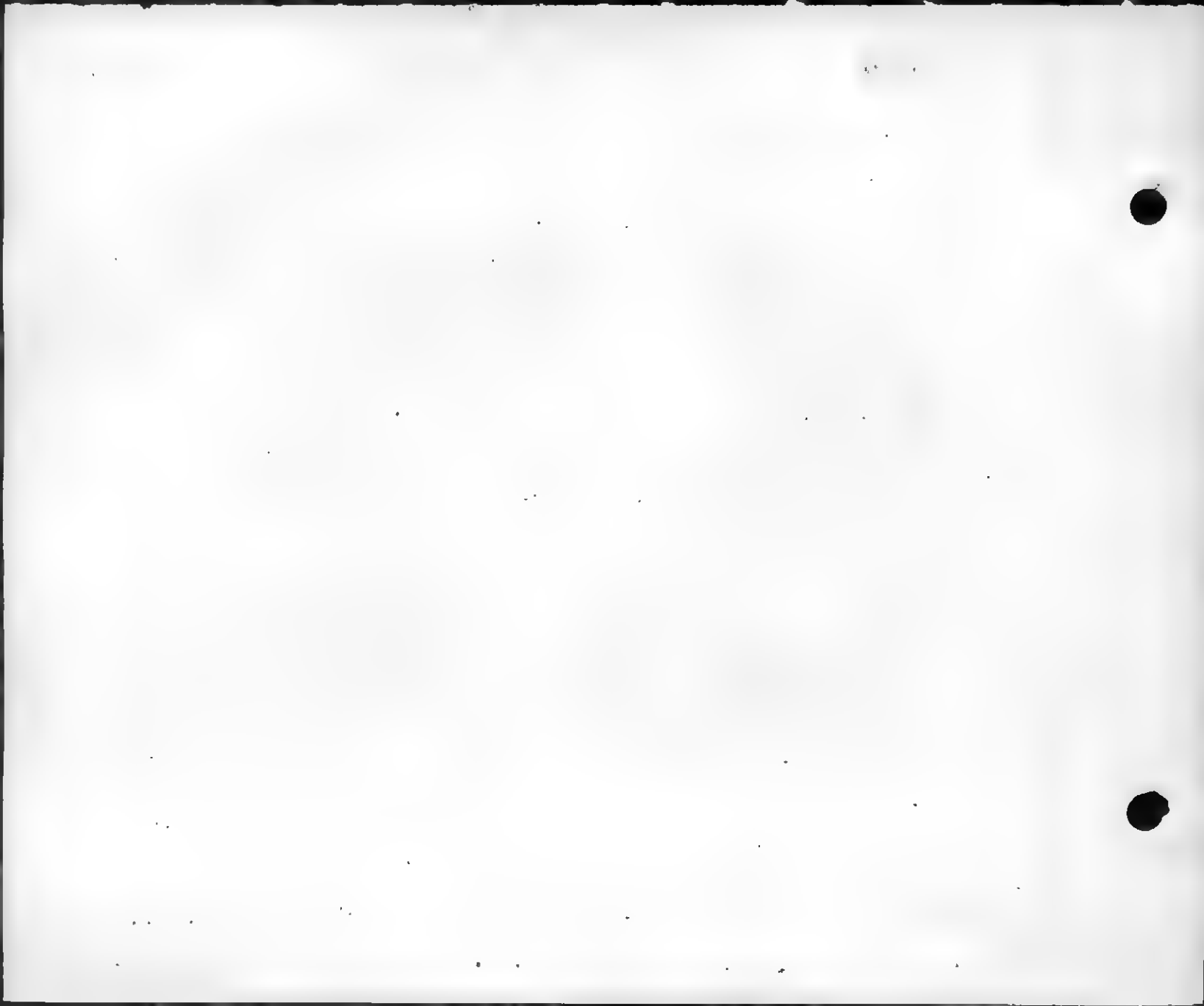
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**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

02574

02539

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BETHESDA</u> c. LENGTH OF STAY IN 1b <u>156 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BETHESDA-SILVERSPRING N.H.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING 1-1</u> d. STREET ADDRESS <u>8508 16th ST. APT. #404</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>ABRAHAM N. PARSON</u> First Middle Last			4. DATE OF DEATH <u>FEB 11, 1966</u> Month Day Year				
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>APR. 21, 1888</u>		9. AGE (in years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLEANING BUSINESS</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Nota E. Parson</u>				
14. MOTHER'S MAIDEN NAME <u>unk.</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				
16. SOCIAL SECURITY NO. <u>(SUN)</u>			17. INFORMANT <u>NORMAN PARSON</u> Address <u>1000 GREENLEAF RD DISTRICT HEIGHTS MD</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Stomach - metastases</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>over 6 mo.</u>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June, 1947</u> , to <u>Feb 11, 1966</u> , that (I) (we) last saw the deceased alive on <u>Feb 9, 1966</u> , and that death occurred at <u>2:30 AM</u> , from the causes and on the date stated above.					
22a. SIGNATURE <u>Louis H. Shuman</u> 22c. PHYSICIAN'S NAME (Type) <u>Louis H. Shuman, M.D.</u>					22b. DATE SIGNED <u>FEB 11, 1966</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22d. ADDRESS <u>1635 Mass Ave NW, Wash. DC 20036</u>					23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		
23b. DATE THEREOF <u>2/13/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Lebanon Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hyattsville Md</u>			
24. FUNERAL DIRECTOR ADDRESS <u>B. DANZANSKY &amp; SONS 3501 14th St. NW</u>					25a. REC'D BY REGISTRAR <u>FEB 11 1966</u> 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



FOR STATE  
HEALTH DEPT.

02575

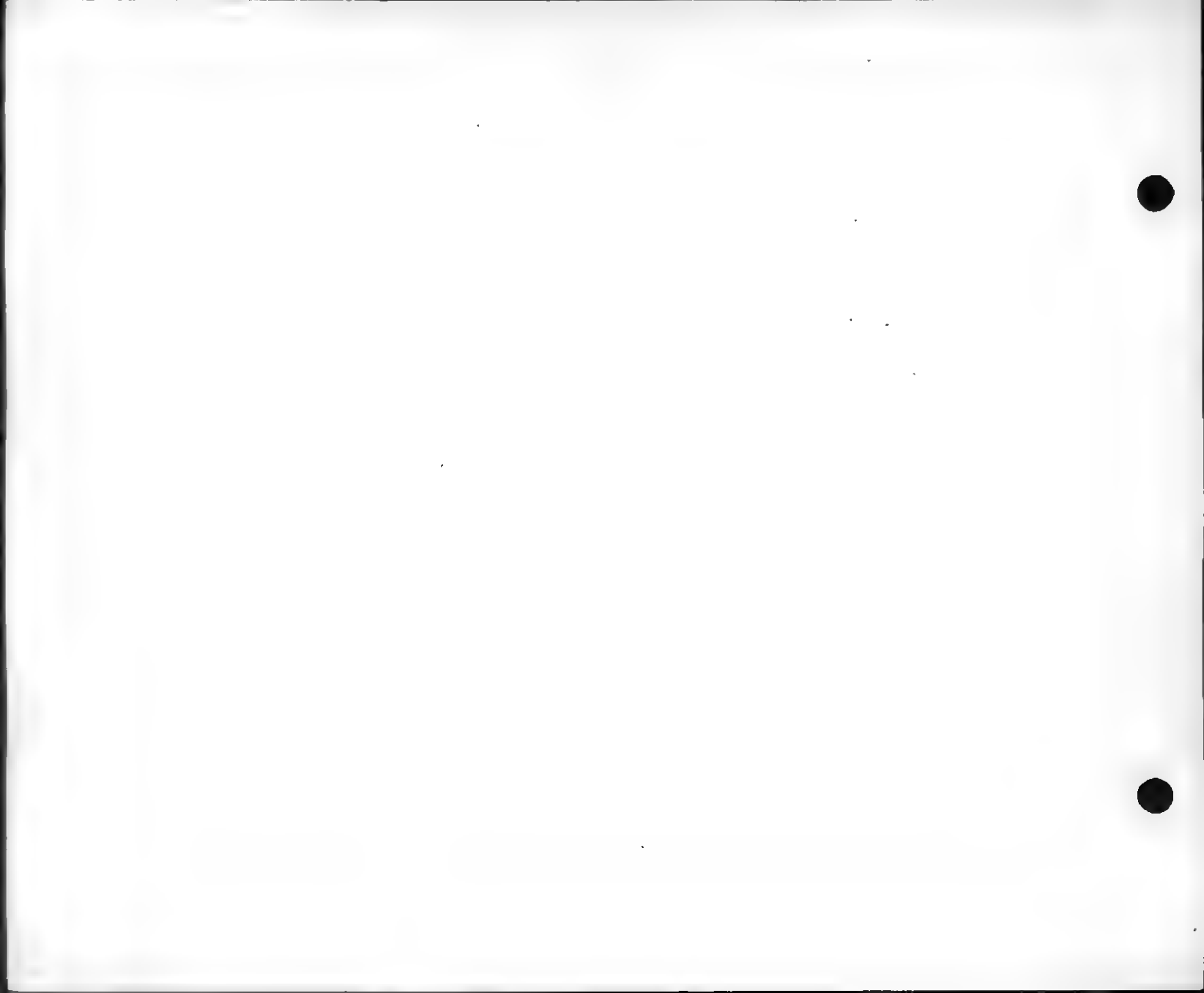
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02540

1 PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Montgomery Co.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Takoma Park</i>		c. LENGTH OF STAY IN TB	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Washington Hospital</i>		d. STREET ADDRESS <i>500 Tulip Ave</i>	
3 NAME OF DECEASED (Type or print) First Middle Last <i>Sarah Miller Parsons</i>		4. DATE OF DEATH Month Day Year <i>2 22 1966</i>	
5 SEX <i>Female</i>	6 COLOR OR RACE <i>White</i>	7 MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <i>1-27-85</i>
9 AGE (In years last birthday) <i>81</i> yrs		10 IF UNDER 1 YEAR Months Days Hours Min	
10a USUAL OCCUPATION (Give kind of work done during most of work life, then fret red) <i>at home</i>		10b KIND OF BUSINESS OR INDUSTRY	
11 BIRTHPLACE (State or foreign country) <i>Tenn</i>		12 CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Joseph Miller</i>		14 MOTHER'S MAIDEN NAME <i>Elizabeth Sweeney Thorne</i>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO	
17 INFORMANT <i>Mr. Ruth Brandt</i>		Address <i>500 Tulip Ave Takoma Park Md</i>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>Acute coronary insufficiency;</i> DUE TO (b) <i>Arteriosclerotic heart disease.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19 WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)	20f (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Belden R. Reap</i> M.D.		22. DATE SIGNED <i>Feb. 22, 1966</i>	
EXAMINER'S NAME (Type) <i>BELDEN R. REAP M.D.</i>		Address (Street, city, town or county) <i>Washington D.C.</i>	
23a BURIAL, CREMATION, REMOVAL (Specify) <i>V</i>	23b. DATE THEREOF <i>2-25-1966</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Farmwood Cemetery</i>	23d. LOCATION (City or town) (County) (State) <i>Cumberland Co. New Jersey</i>
24. FUNERAL DIRECTOR <i>Arthur Walters</i>		25a REC'D BY REGISTRAR DATE <i>B 25 1966</i>	
25b REGISTRAR'S SIGNATURE <i>Arthur Walters</i>		25c REGISTRAR'S SIGNATURE <i>Arthur Walters</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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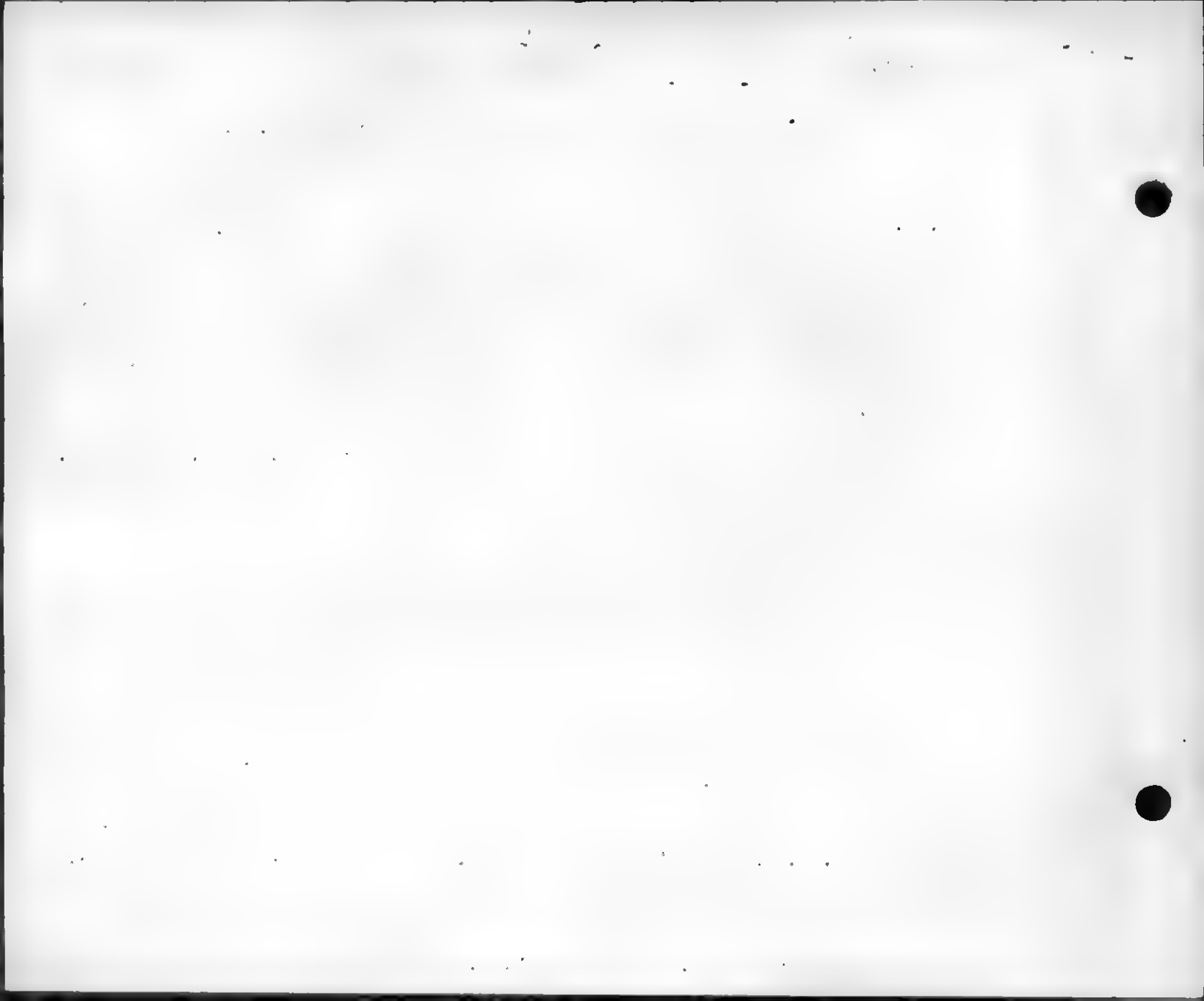
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02576

CERTIFICATE OF DEATH

02541

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D. C.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, (rural)</u>			c. LENGTH OF STAY IN 1b <u>8 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>U. S. Naval Hospital</u>				d. STREET ADDRESS <u>15 Sextant Green, S. W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Pearson</u>				4. DATE OF DEATH Month <u>February</u> Day <u>19</u> Year <u>1966</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>19 Feb. 1966</u>	
9. AGE (In years last birthday) <u>8 yrs</u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				13. FATHER'S NAME <u>Ronald K. Pearson</u>			
14. MOTHER'S MAIDEN NAME <u>Ione Marie Baston</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>NA</u>				17. INFORMANT <u>Ronald K. Pearson</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from <u>Feb. 19</u> , 19 <u>66</u> , to <u>Feb. 19</u> , 19 <u>66</u> that (X) (we) last saw the deceased alive on <u>Feb. 19</u> , 19 <u>66</u> , and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>R. F. Swanger</u>				22b. DATE SIGNED <u>Feb. 21, 1966</u>		22c. PHYSICIAN'S NAME (Type) <u>R. F. Swanger LT MC USN</u>	
22d. ADDRESS <u>U. S. Naval Hospital, Bethesda, Md.</u>				23a. REC'D BY REGISTRAR			
23b. DATE THEREOF <u>2-24-1966</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cemetery Arlington, Virginia</u>			
23d. LOCATION (City or Town) (County) (State) <u>Virginia</u>				24. FUNERAL DIRECTOR <u>Simmons Brothers Funeral Home</u>			
25a. ADDRESS <u>1661 Goodhope Road, S. E. Washington, D. C.</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

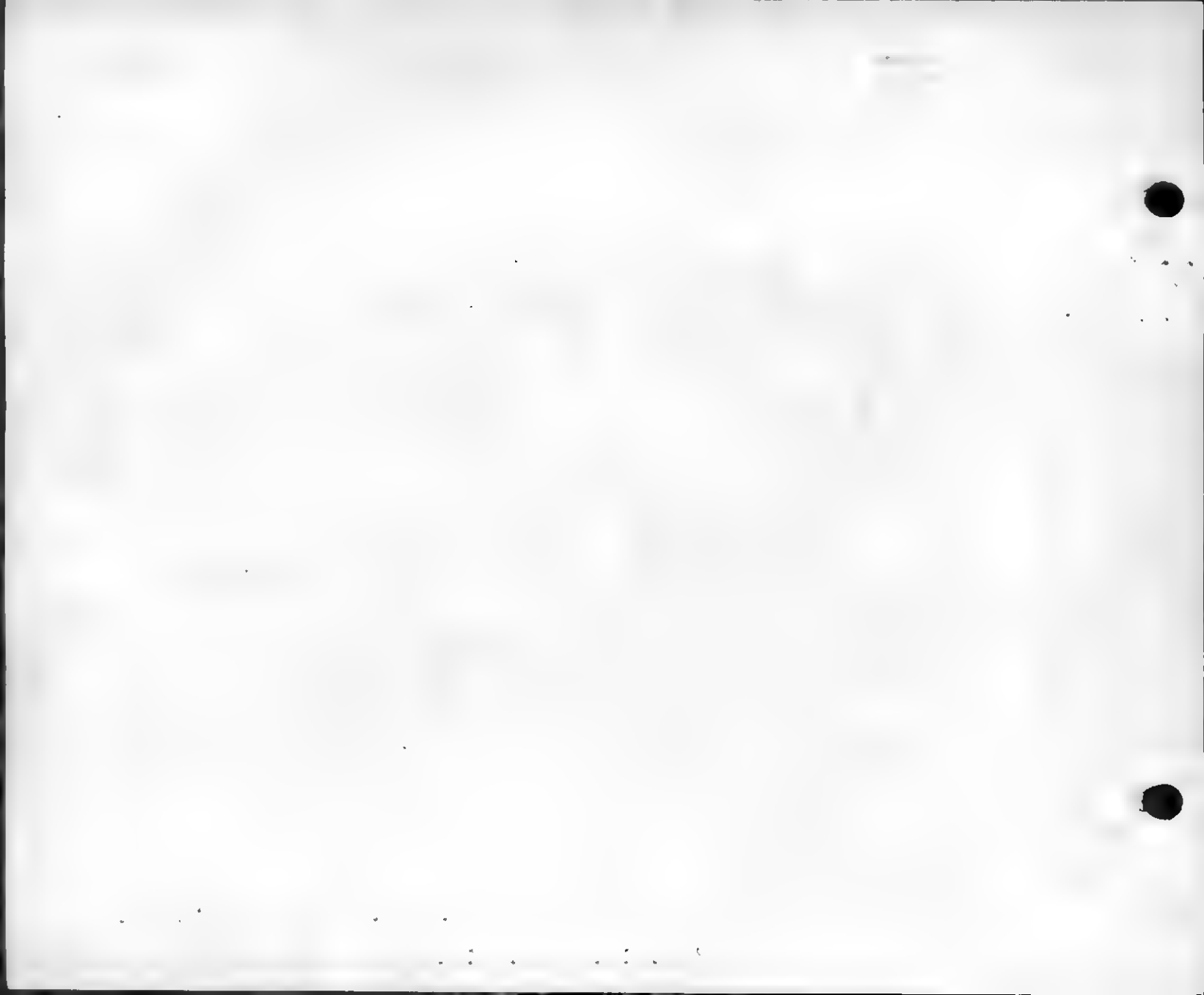


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

<div>Items 18&amp;21 Film G375 761106</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div>															
<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8711 Leonard Drive</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> d. STREET ADDRESS <u>8711 Leonard Dr.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Louisa Rita Pearson</u>				<b>4. DATE OF DEATH</b> Month <u>2</u> - Day <u>9</u> - Year <u>1966</u>											
<b>5. SEX</b> <u>Fe</u>		<b>6. COLOR OR RACE</b> <u>Cauc</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>8-5-1908</u>		<b>9. AGE</b> (In years last birthday) <u>57</u> yrs. <table border="1"> <tr> <th>IF UNDER 1 YEAR</th> <th>IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days	<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>SECRETARY-Attorney</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.														
Months	Days														
<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S. Gov't.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Connecticut</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>											
<b>13. FATHER'S NAME</b> <u>George H. Pearson</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret B. Conway</u>											
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>-</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> <u>Miss ADA Henry</u>		Address <u>Silver Spring, MD</u> <u>8711 Leonard Drive</u>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>Acute coronary insufficiency</u> (b) <u>Coronary artery heart disease</u> (c) <u>(PENDING)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>															
<b>20a. EXTERNAL CAUSE WAS</b> PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of Item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>Belden R. Reap</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>22. DATE SIGNED</b> <u>Febr. 9, 1966</u>							
<b>EXAMINER'S NAME (Type)</b> <u>BELDEN R. REAP</u>				<b>M.D.</b> <u>M.D.</u>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>2-14-1966</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Nat'l. Cem.</u>		<b>23d. LOCATION</b> (City, town or county) (State) <u>Arlington, Va.</u>							
<b>24. FUNERAL DIRECTOR</b> <u>Joseph Gawler's Sons</u>				<b>ADDRESS</b> <u>Ave. N. 5130 Wisc. Ave. N.W. Wash. D.C.</u>		<b>25a. REC'D BY REGISTRAR</b> <u>FEB 16 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN b <b>50 days</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>The Clinical Center Of Health</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> d. STREET ADDRESS <b>3 Pooks Hill Road, Apt. 419</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>Dorit (No middle name) Perk</b>			4. DATE OF DEATH Month <b>February</b> Day <b>7</b> Year <b>1966</b>						
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 10, 1960</b>		9. AGE (In years last birthday) <b>6</b> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>			11. BIRTHPLACE (County & State, or foreign country) <b>Israel</b>		12. CITIZEN OF WHAT COUNTRY? <b>Israel</b>	
13. FATHER'S NAME <b>Kalman Perk</b>					14. MOTHER'S MAIDEN NAME <b>Ruth Yahalom</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>The Medical Record The Clinical Center, Bethesda 14, Maryland</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intracerebral hemorrhage</b> 143 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Probable generalized Fungal Infection</b> DUE TO (c) <b>Acute Lymphocytic Leukemia</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
INTERVAL BETWEEN ONSET AND DEATH <b>15 Days</b> <b>20 Days</b> <b>14 Months</b>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
MEDICAL CERTIFICATION									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>December 19, 1965</b> , to <b>February 7, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>February 7, 1966</b> , and that death occurred at <b>5:10 PM</b> , from the causes and on the date stated above.									
22a. SIGNATURE <i>Theodore S. Zimmerman</i> 22c. PHYSICIAN'S NAME (Type) <b>Theodore S. Zimmerman, MD.</b>					22b. DATE SIGNED <b>7 February 1966</b> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE THEREOF <b>2/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Gdn.</b>		23d. LOCATION (City, town or county) (State) <b>Falls Church, Virginia</b>			
24. FUNERAL DIRECTOR <b>B. DANZANSKY &amp; SONS</b>					25a. REC'D BY REGISTRAR <b>Charles Judge</b> 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
ADDRESS <b>35 01 14th St. N.W.</b>					DATE <b>FEB 14 1966</b>				



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

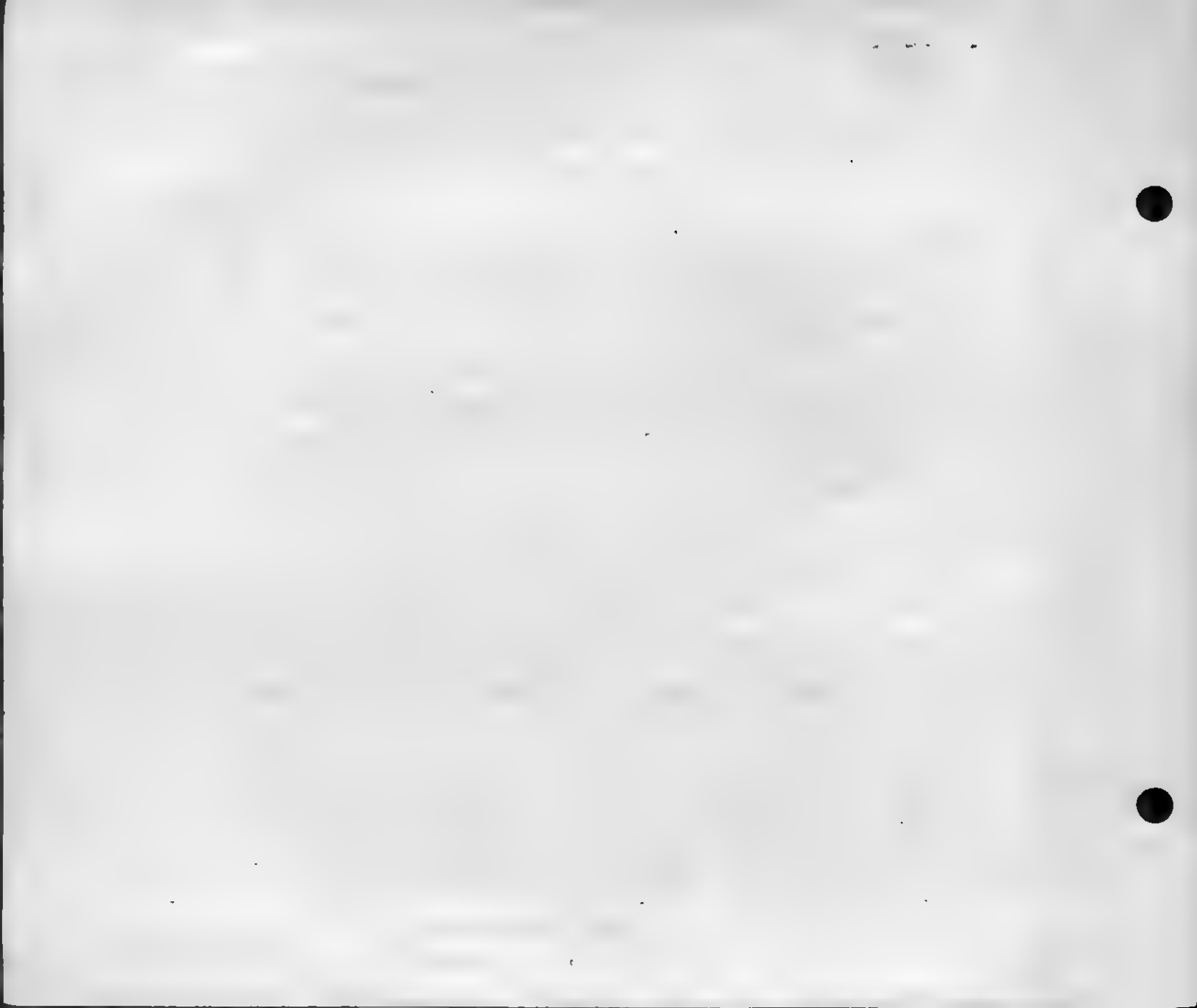
02579

02544

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u>			
c. LENGTH OF STAY IN 1b <u>3 1/2 years</u>				d. STREET ADDRESS <u>805 BRICE ROAD</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY ELIZABETH PERRY</u>				4. DATE OF DEATH <u>Feb 3 1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 20 1887</u>	
9. AGE (In years last birthday) <u>78 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (County & State, or foreign country) <u>BROOKTON MASS</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John PERRY THORNELL</u>				14. MOTHER'S MAIDEN NAME <u>MARY HAYES</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>013-09-0018</u>		17. INFORMANT <u>MRS Fred McCANN 805 BRICE ROAD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY</u> <u>1201</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular disease with hypertension</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-29</u> ....., 19 <u>63</u> , to <u>2-3</u> ....., 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>1-21</u> ....., 19 <u>66</u> , and that death occurred at <u>11:15 AM</u> on the causes and on the date stated above.							
22a. SIGNATURE <u>Sarah E. Glover</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>SARAH E GLOVER</u>	
22d. ADDRESS <u>1612 CEDAR LAKE KENSINGTON MD</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/5/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Patricks</u>		23d. LOCATION (City, town or county) (State) <u>Brookton, Mass.</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Tyson Wheeler Funeral Home</u>				25a. REC'D BY REGISTRAR <u>FEB 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02580 CERTIFICATE OF DEATH 02540

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u> c. LENGTH OF STAY IN 1b <u>7 mo 10 da</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Kensington GARDEN</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Bethesda</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> d. STREET ADDRESS <u>6820 Millwood Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELMER</u> First <u>S</u> Middle <u>Petry</u> Last		4. DATE OF DEATH <u>Feb</u> Month <u>25</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1887</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MINISTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Church</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Ohio</u>
13. FATHER'S NAME <u>Michael Petry</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>275-10-8557</u>	17. INFORMANT <u>6820</u> Address <u>C.A. Petry - Millwood Road, Bethesda, Md.</u>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>446A</u> DUE TO <u>Nephrosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Atherosclerosis</u> (b) <u>Arteriosclerosis</u> (c) <u>Brachycephalitis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3-6 days</u> <u>Unknown</u> <u>Unknown</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>May 7</u> , 19 <u>65</u> to <u>Feb 25</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 25</u> , 19 <u>66</u> , and that death occurred at <u>9:20 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George Sharp</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George Sharp</u>		22d. ADDRESS <u>Kensington, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial-transit</u>	23b. DATE THEREOF <u>2/28/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dade Memorial Park</u>	23d. LOCATION (City, town or county) (State) <u>Opalocka, Florida</u>
24. FUNERAL DIRECTOR <u>Lyson Wheeler</u> ADDRESS <u>Federal Home-1331 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR <u>MAR 3 1966</u>	25b. REGISTRAR'S SIGNATURE <u>James Judge</u>



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE HEALTH DEPT

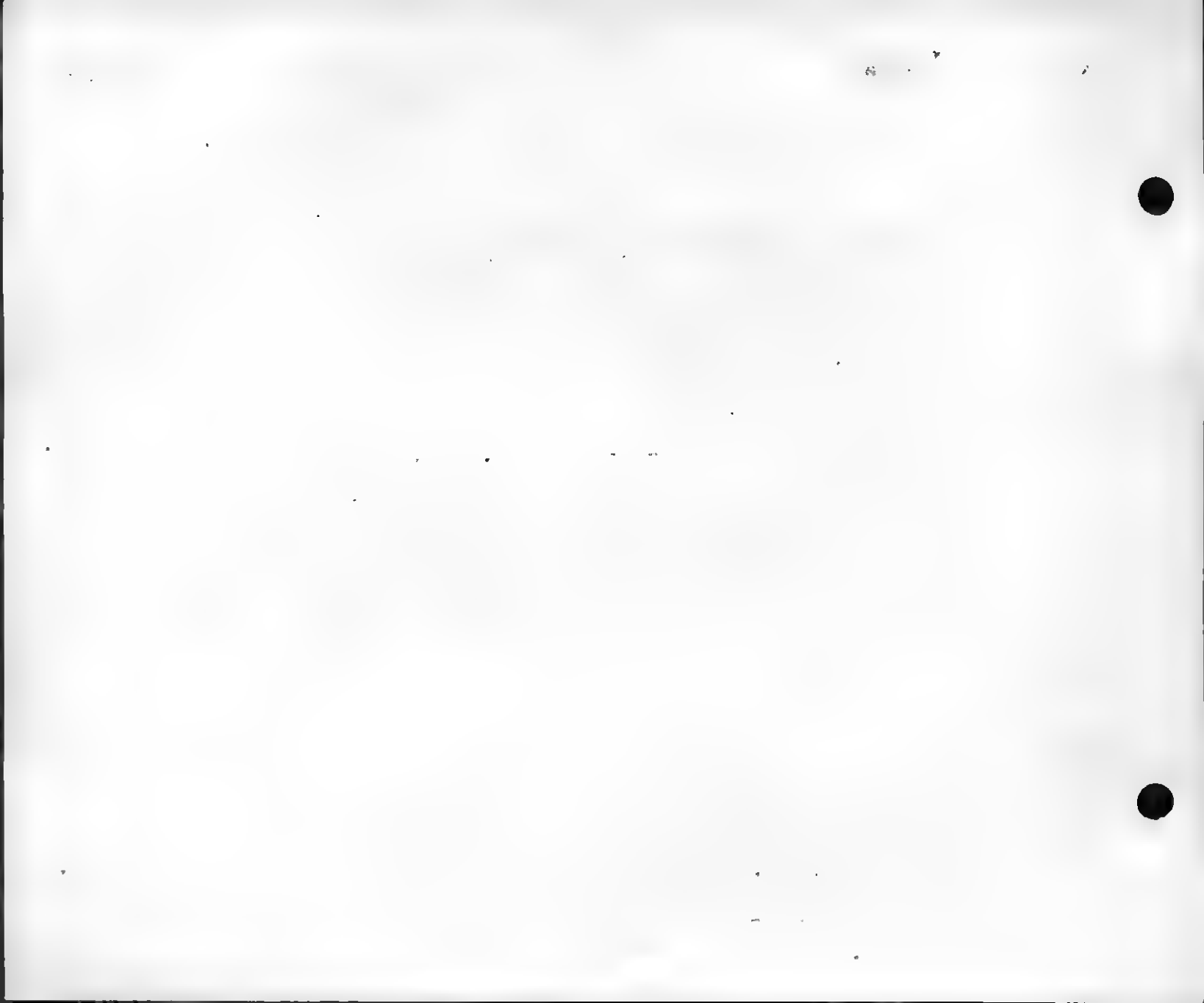
02589

02546

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH a COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) a STATE <u>D.C.</u> b COUNTY <u>D.C.</u>	
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c LENGTH OF STAY in 1b <u>16 Months</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Nursing Home</u>		e CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>	
f STREET ADDRESS <u>3517 Rodman Street</u>		g IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First <u>Hugh</u> Middle <u>Edward</u> Last <u>Phillips</u>		4 DATE OF DEATH Month <u>Feb</u> Day <u>21</u> Year <u>1966</u>	
5 SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>2/25/1881</u>
9 AGE (In years last birthday) <u>84</u> yrs		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Real Estate</u>	
10b KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>	
12 CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13 FATHER'S NAME <u>Melvin W. Phillips</u>	
14 MOTHER'S MAIDEN NAME <u>Ester Virginia Hickson</u>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16 SOCIAL SECURITY NO <u>578-50-1497</u>		17 INFORMANT <u>Daughter</u> <u>Mrs. F.M. Hoffheins</u> Address <u>Same as Item 2.</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Bronchial -</u> DUE TO (b) <u>Fracture of Left Hip -</u> DUE TO (c) <u>Generalized Arterio Sclerosis -</u> Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>21 days</u> <u>Years</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTE TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Fell and fractured left hip</u>	
20c TIME OF INJURY Month Day, Year Hour am. <u>2/11/1966</u> pm		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Nursing Home -</u>
20f (City or town) <u>Kensington Mont. Md.</u>		20g (County) <u>Montgomery</u>	
20h (State) <u>Md.</u>		21 I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		22. DATE SIGNED <u>2/21/66</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b DATE THEREOF <u>2-24-66</u>	23c NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d LOCATION (City or Town) (County) (State) <u>Suitland, Maryland</u>
24 FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY</u>		25a REC'D BY REGISTRAR <u>FEB 24 1966</u>	
25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

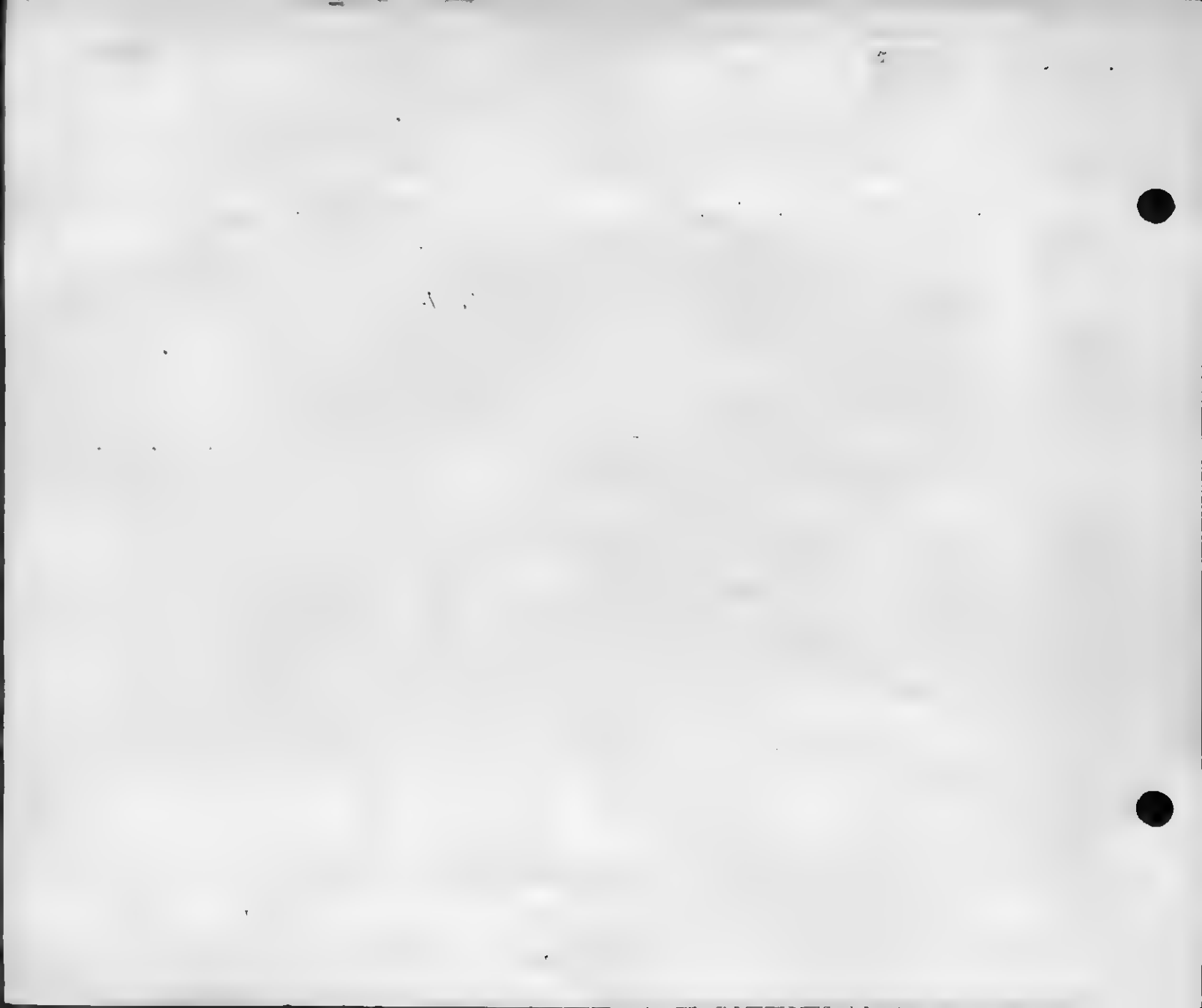
## CERTIFICATE OF DEATH

02582

02547

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>15 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Congressional Manor Sanitarium</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <u>D.C.</u> b. COUNTY <u>1</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Washington</u> d. STREET ADDRESS <u>6345 Western Ave. N.W.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>MARY BROGDEN PINNEY</u>		<b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>24</u> Year <u>1966</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>Sept. 17-1873</u>	
<b>9. AGE</b> (In years last birthday) <u>92</u> yrs		<b>10. IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>11. IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S.</u>		<b>13. FATHER'S NAME</b> <u>Arthur Brogden</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary Mercer</u>	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>578-64-5968</u>		<b>17. INFORMANT</b> <u>Frank Pinney, 6345 Western Ave. N.W. D.C. Son</u>	
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>PULMONARY EMBOLUS</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerotic C.V. Disease</u> (a), stating the underlying cause last. DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)					
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	
<b>20f. (City or town)</b>		<b>(County)</b>		<b>(State)</b>	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Feb 24, 1966</u> <b>to</b> <u>Feb 24, 1966</u> , <b>that (I) (we) last saw the deceased alive on</b> <u>Feb 24, 1966</u> , <b>and that death occurred at</b> <u>11:05 M.</u> <b>from the causes and on the date stated above</b>					
<b>22a. SIGNATURE</b> <u>Delbert E. DeLawter</u>		<b>22b. DATE SIGNED</b> <u>2/25/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>DELBERT E. DELAWTER</u>	
<b>22d. ADDRESS</b> <u>8025 ABERDEEN RD Bethesda Md</u>		<b>22e. M.D.</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>23b. DATE THEREOF</b> <u>2/28/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington National</u>	
<b>23d. LOCATION (City, town or county)</b> <u>Arlington, Virginia</u>		<b>(State)</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Tyson Wheeler</u>		<b>24a. ADDRESS</b> <u>Rockville, Maryland</u>		<b>24b. REC'D BY REGISTRAR</b> <u>MAR 1 1966</u>	
<b>24c. REGISTRAR'S SIGNATURE</b> <u>John J. Judge</u>		<b>24d. REGISTRAR'S NAME</b> <u>John J. Judge</u>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

02583

CERTIFICATE OF DEATH

02548

1 PLACE OF DEATH a CO. NTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a STATE <u>Maryland</u> b COUNTY <u>Montgomery</u>	
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington Washington D.C.</u>	
d NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d STREET ADDRESS <u>3000 Elliecott St. NW</u>	
3 NAME OF DECEASED (Type or print) <u>MARGARET Elizabeth Pirie</u>		4 DATE OF DEATH <u>Feb 3 1966</u>	
5 SEX <u>Female</u>	6 COLOR OR RACE <u>White</u>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>6/14/1882</u>
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bookkeeper</u>		10b KIND OF BUSINESS OR INDUSTRY <u>Wash. Monumental Co.</u>	
11 BIRTHPLACE (County & State or foreign country) <u>Philadelphia, Penn</u>		12 CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13 FATHER'S NAME <u>Garnet N. Schwemmer</u>		14 MOTHER'S MAIDEN NAME <u>Anna STURGES MANUEL</u>	
15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16 SOCIAL SECURITY NO <u>578-34-1053</u>	
17 INFORMANT <u>Raymond A. Pirie</u>		Address <u>3000 Elliecott St. NW</u>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary congestion and edema</u> 6000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>chronic pyelonephritis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 18</u> , 19 <u>66</u> , to <u>Feb 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Feb 2</u> 19 <u>66</u> , and that death occurred at <u>2:30</u> A.M. from causes and on the date stated above.			
22a SIGNATURE <u>[Signature]</u>		22b DATE SIGNED <u>Feb 3, 1966</u>	
22c PHYSICIAN'S NAME (Type) <u>[Signature]</u>		22d ADDRESS <u>921-20th St NW</u>	
23a BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b DATE THEREOF <u>2/7/66</u>	
23c NAME OF CEMETERY OR CREMATORY <u>GLENWOOD</u>		23d LOCATION (City or town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>JOSEPH GAULERS SONS</u>		25a REC'D BY REGISTRAR <u>WILKINSON AVE. WASHINGTON, D.C.</u>	
25b REGISTRAR'S SIGNATURE <u>[Signature]</u>		DATE <u>FEB 9 1966</u>	

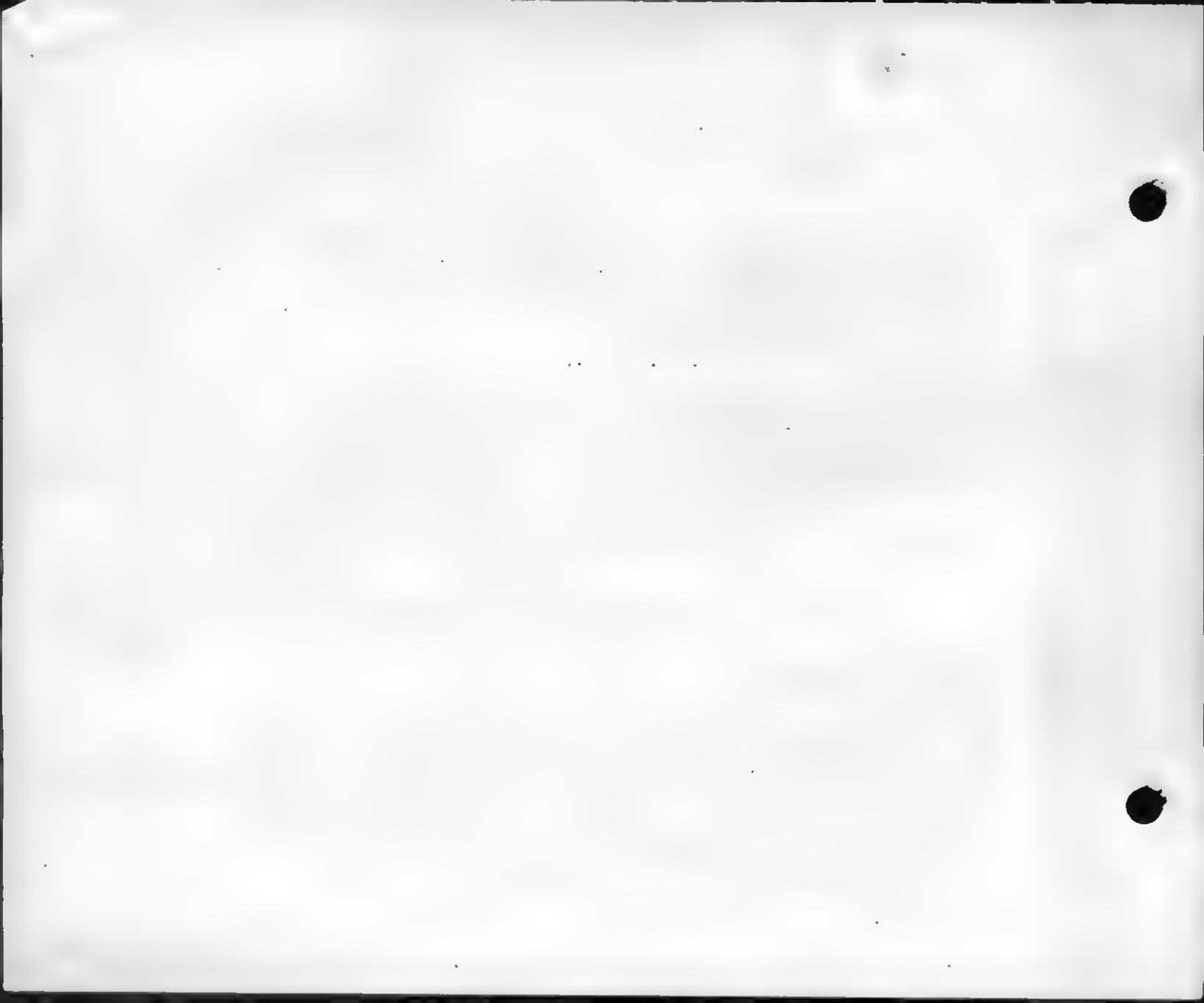




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
02584 CERTIFICATE OF DEATH 02549

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> c. LENGTH OF STAY IN 1b <b>1218 Dale Drive</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b> d. STREET ADDRESS <b>1218 Dale Drive</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Pauline C. Plaskett</b>			4. DATE OF DEATH Month Day Year <b>Feb. 19 19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>Sept. 1, 1881</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U. S. Govt.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Charles Coleman</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Haislip</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT Address <b>Rosemary Louft Same as #2</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis - myocardial infarction</b> DUE TO (b) <b>Sen. arteriosclerotic changes in coronary arteries</b> DUE TO (c) <b>2 yr.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (U) (this hospital) attended the deceased from <b>1958</b> , 19, to <b>19 Feb</b> , 1966, that (U) (we) last saw the deceased alive on <b>19 Feb</b> 1966, and that death occurred at <b>7:30 AM</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Ernest Harmon</b>				22b. DATE SIGNED <b>19 Feb 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Ernest Harmon</b>				22d. ADDRESS <b>9301 Colesville Rd, Silver Sp., Md</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>2/19/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>	
23d. LOCATION (City, town or county) (State) <b>Washington DC</b>					
24. FUNERAL DIRECTOR <b>J. Wm. Lees Sons</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>300 4th St., NE, Wash. D.C.</b>				25b. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

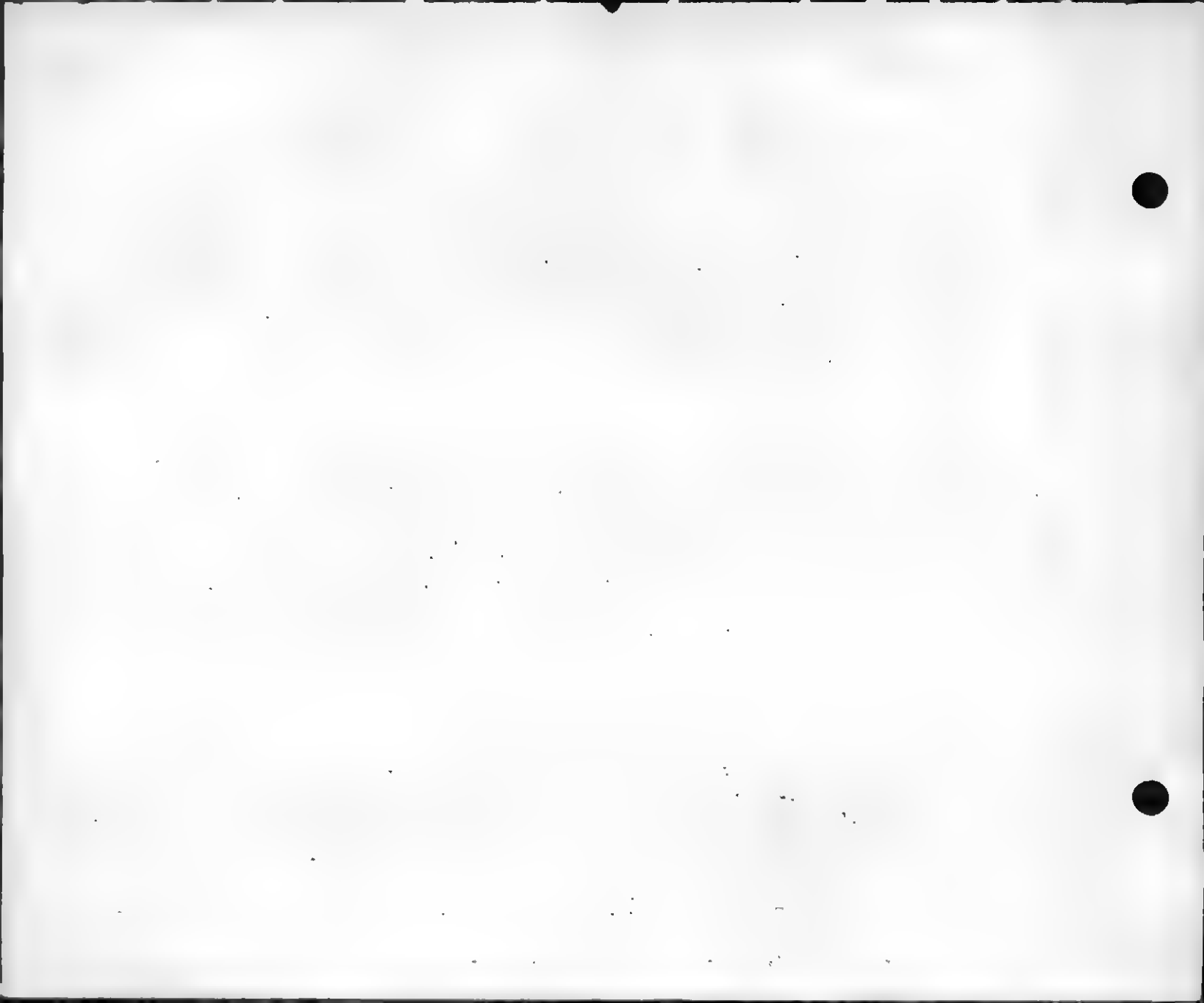
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

02585

02550

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u> c. LENGTH OF STAY IN 1b <u>10 days + 8 hrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASHINGTON SANITARIUM AND HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>ROCKVILLE</u> 15-1 d. STREET ADDRESS <u>516 NELSON STREET</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>HAROLD</u> Last <u>PORSCH</u>			4. DATE OF DEATH Month <u>February</u> Day <u>5</u> Year <u>1966</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-6-26</u>		9. AGE (in years last birthday) <u>39</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOT SITE PLANNER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. GOVERNMENT</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Erie PENNA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM E. PORSCH</u>				14. MOTHER'S MAIDEN NAME <u>ELEANORE BUQUO</u>					
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>210-18-6193</u>		17. INFORMANT <u>Mary Lou Porsch</u> Address <u>516 Nelson Street Rockville, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Young's Aspiration, cardiac arrest</u> DUE TO (b) <u>prolonged myocardial infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ruptured intracranial aneurysm</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral artery aneurysm and clipping of aneurysm 7/1/66</u>								INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2/26</u> , 19 <u>66</u> , to <u>2/3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2/4</u> , 19 <u>66</u> and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>John T. Lord</u>				M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>2/5/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>John T. Lord</u>				22d. ADDRESS <u>1015 Spring Street Silver Spring, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-9-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pedar Grove Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Chambersburg, Penna.</u>			
24. FUNERAL DIRECTOR <u>Warner E. Purphrey, Inc.</u> ADDRESS <u>8134 Niagara Avenue Silver Spring, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>W. Charles Judge</u>			



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body in any way within 72 hours after death.

VR A15ME (5)  
6M 1/66

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

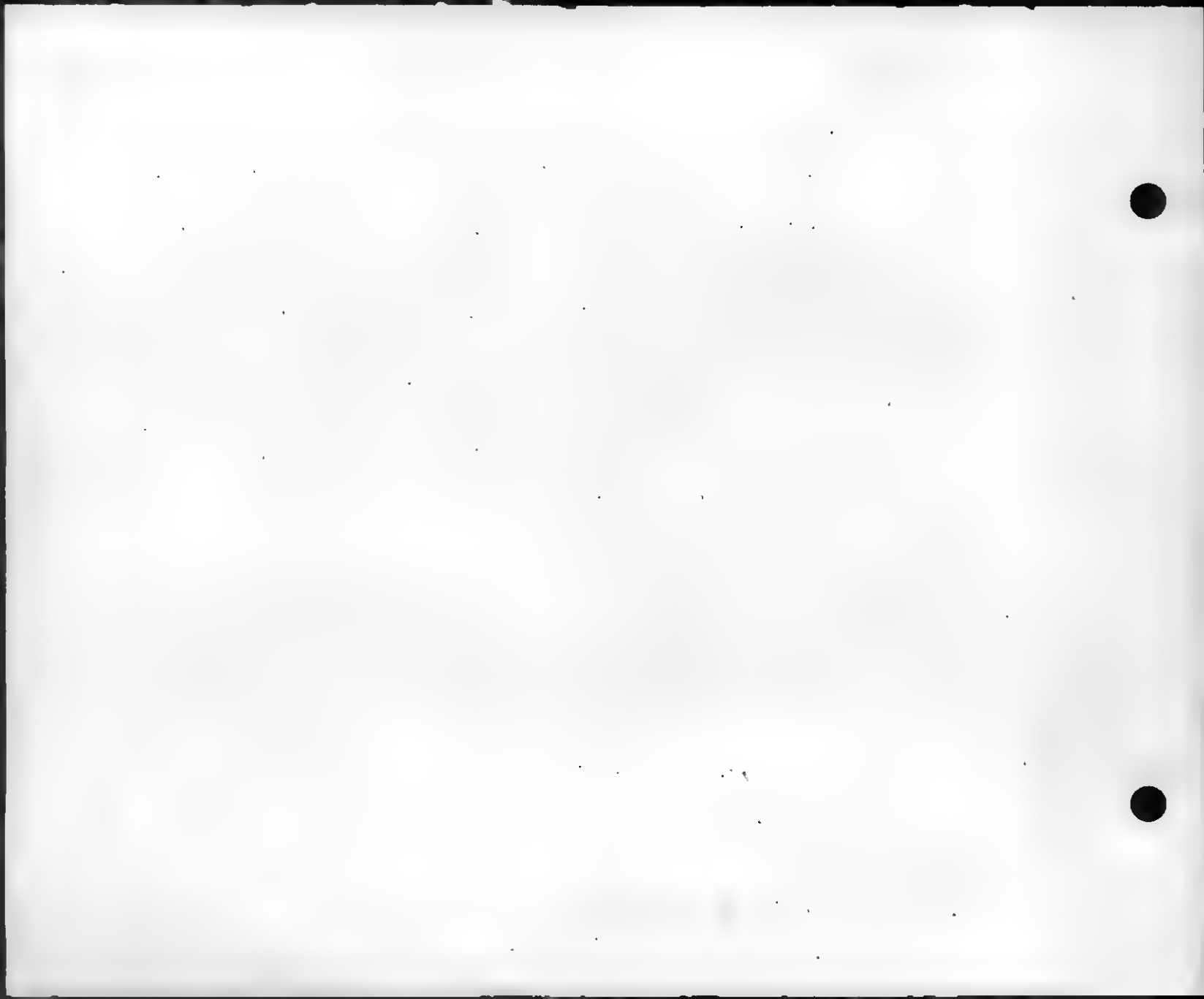
1 PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 26 mins		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6404-Wilson Ln.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3 NAME OF DECEASED (Type or print) <u>Rachel</u> First Middle Last <u>Lesner</u>		4 DATE OF DEATH <u>Feb.</u> Month <u>24</u> Day <u>19</u> Year <u>66</u>	
5 SEX <u>female</u>	6 CO. OR OR RACE <u>white</u>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <u>7/15/77</u> 88
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Russia</u>
13. FATHER'S NAME <u>Joshua Shapiro</u>		14. MOTHER'S MAIDEN NAME <u>Rosa Katz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> <u>no</u>		16. SOCIAL SECURITY NO <u>478-62-6630</u>	
17. INFORMANT <u>Sylvia Goodman</u> Address <u>same as above</u>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchio. Pneumonia.</u> DUE TO (b) <u>Cardio Vascular Disease -</u> DUE TO (c) <u>Gen. Generalized Arterio Sclerosis -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days.</u> <u>years.</u> <u>years.</u>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John B. Ball</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2/24/66</u>	
		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>2/27/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LUBAVITCH CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>BUFFALO N.Y.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME</u> 4217-92nd N.W.		25a. REC'D BY REGISTRAR <u>FEB 28 1966</u> DATE	25b. REGISTRAR'S SIGNATURE <u>John C. Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Mont</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevier Springs</u> c. LENGTH OF STAY IN 1b <u>1 wk</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Holy Cross Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevier Springs</u> d. STREET ADDRESS <u>8931 Brookville Rd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Mary H. Potts</u>			4. DATE OF DEATH Month <u>2</u> Day <u>15</u> Year <u>1966</u>			5. SEX <u>F</u>			6. COLOR OR RACE <u>C</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>3/2/11</u>			9. AGE (In years last birthday) <u>54</u> yrs.			10. UNDER 1 YEAR <input type="checkbox"/> 1 YEAR <input type="checkbox"/> 2 YEARS <input type="checkbox"/> 3 YEARS <input type="checkbox"/> 4 YEARS <input type="checkbox"/> 5 YEARS <input type="checkbox"/> 6 YEARS <input type="checkbox"/> 7 YEARS <input type="checkbox"/> 8 YEARS <input type="checkbox"/> 9 YEARS <input type="checkbox"/> 10 YEARS <input type="checkbox"/> 11 YEARS <input type="checkbox"/> 12 YEARS <input type="checkbox"/> 13 YEARS <input type="checkbox"/> 14 YEARS <input type="checkbox"/> 15 YEARS <input type="checkbox"/> 16 YEARS <input type="checkbox"/> 17 YEARS <input type="checkbox"/> 18 YEARS <input type="checkbox"/> 19 YEARS <input type="checkbox"/> 20 YEARS <input type="checkbox"/> 21 YEARS <input type="checkbox"/> 22 YEARS <input type="checkbox"/> 23 YEARS <input type="checkbox"/> 24 YEARS <input type="checkbox"/> 25 YEARS <input type="checkbox"/> 26 YEARS <input type="checkbox"/> 27 YEARS <input type="checkbox"/> 28 YEARS <input type="checkbox"/> 29 YEARS <input type="checkbox"/> 30 YEARS <input type="checkbox"/> 31 YEARS <input type="checkbox"/> 32 YEARS <input type="checkbox"/> 33 YEARS <input type="checkbox"/> 34 YEARS <input type="checkbox"/> 35 YEARS <input type="checkbox"/> 36 YEARS <input type="checkbox"/> 37 YEARS <input type="checkbox"/> 38 YEARS <input type="checkbox"/> 39 YEARS <input type="checkbox"/> 40 YEARS <input type="checkbox"/> 41 YEARS <input type="checkbox"/> 42 YEARS <input type="checkbox"/> 43 YEARS <input type="checkbox"/> 44 YEARS <input type="checkbox"/> 45 YEARS <input type="checkbox"/> 46 YEARS <input type="checkbox"/> 47 YEARS <input type="checkbox"/> 48 YEARS <input type="checkbox"/> 49 YEARS <input type="checkbox"/> 50 YEARS <input type="checkbox"/> 51 YEARS <input type="checkbox"/> 52 YEARS <input type="checkbox"/> 53 YEARS <input type="checkbox"/> 54 YEARS <input type="checkbox"/> 55 YEARS <input type="checkbox"/> 56 YEARS <input type="checkbox"/> 57 YEARS <input type="checkbox"/> 58 YEARS <input type="checkbox"/> 59 YEARS <input type="checkbox"/> 60 YEARS <input type="checkbox"/> 61 YEARS <input type="checkbox"/> 62 YEARS <input type="checkbox"/> 63 YEARS <input type="checkbox"/> 64 YEARS <input type="checkbox"/> 65 YEARS <input type="checkbox"/> 66 YEARS <input type="checkbox"/> 67 YEARS <input type="checkbox"/> 68 YEARS <input type="checkbox"/> 69 YEARS <input type="checkbox"/> 70 YEARS <input type="checkbox"/> 71 YEARS <input type="checkbox"/> 72 YEARS <input type="checkbox"/> 73 YEARS <input type="checkbox"/> 74 YEARS <input type="checkbox"/> 75 YEARS <input type="checkbox"/> 76 YEARS <input type="checkbox"/> 77 YEARS <input type="checkbox"/> 78 YEARS <input type="checkbox"/> 79 YEARS <input type="checkbox"/> 80 YEARS <input type="checkbox"/> 81 YEARS <input type="checkbox"/> 82 YEARS <input type="checkbox"/> 83 YEARS <input type="checkbox"/> 84 YEARS <input type="checkbox"/> 85 YEARS <input type="checkbox"/> 86 YEARS <input type="checkbox"/> 87 YEARS <input type="checkbox"/> 88 YEARS <input type="checkbox"/> 89 YEARS <input type="checkbox"/> 90 YEARS <input type="checkbox"/> 91 YEARS <input type="checkbox"/> 92 YEARS <input type="checkbox"/> 93 YEARS <input type="checkbox"/> 94 YEARS <input type="checkbox"/> 95 YEARS <input type="checkbox"/> 96 YEARS <input type="checkbox"/> 97 YEARS <input type="checkbox"/> 98 YEARS <input type="checkbox"/> 99 YEARS <input type="checkbox"/> 100 YEARS <input type="checkbox"/>		
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>			11b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>PHILLIP EAGLEN</u>						14. MOTHER'S MAIDEN NAME <u>CAROLINE BELL</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT <u>CARRIE BARNES</u>			Address <u>8921 Road Brookville</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov</u> , 19 <u>65</u> , to <u>Feb 5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>Feb 4</u> , 19 <u>66</u> , and that death occurred at <u>1:15</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Denzesha</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type)						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>2-19-1966</u>			23c. NAME OF CEMETERY OR CREMATORY <u>CARVER</u>			23d. LOCATION (City, town or county) (State) <u>BELTSVILLE, Maryland</u>		
24. FUNERAL DIRECTOR <u>W.E. Jarvis</u>						25a. REC'D BY REGISTRAR <u>FFB 9</u> DATE <u>1966</u>					
25b. REGISTRAR'S SIGNATURE <u>W.E. Jarvis</u>											





TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>02588</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>02553</p> </div> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RESMOR</u> c. LENGTH OF STAY IN 1b <u>4 Months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Resmor Sanatorium and Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>POTOMAC</u> d. STREET ADDRESS <u>11209 Gainsborough Road Potomac Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) <u>MATTIE</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				<b>8. DATE OF BIRTH</b> <u>June 24, 1887</u> 9. AGE (In years last birthday) <u>78</u> yrs. IF UNDER 1 YEAR: Months <u>  </u> Days <u>  </u> IF UNDER 24 HRS.: Hours <u>  </u> Min. <u>  </u>				<b>4. DATE OF DEATH</b> <u>February 5, 1966</u> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u> 11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u> 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>			
<b>13. FATHER'S NAME</b> <u>JONATHAN Jenkins</u> <b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>  </u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>PATTY LANCASTER</u> <b>16. SOCIAL SECURITY NO.</b> <u>  </u> <b>17. INFORMANT</b> <u>Hospital Record</u> Address <u>  </u>				<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Failure</u> DUE TO <u>Senile Generalized Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinsonism</u>											
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/> <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <u>  </u> p.m. <u>  </u>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>  </u>			
<b>20f. (City or town)</b> <u>  </u>				<b>(County)</b> <u>  </u>				<b>(State)</b> <u>  </u>			
<b>21. I certify that</b> <u>  </u> (this hospital) attended the deceased from <u>Sept 20, 1966</u> to <u>  </u> , 19 <u>  </u> , that <u>  </u> (we) last saw the deceased alive on <u>Feb 5, 1966</u> , and that death occurred at <u>145</u> M. from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <u>P.P. Andrews</u> <b>22c. PHYSICIAN'S NAME (Type)</b> <u>P.P. ANDREWS</u>				<b>22b. DATE SIGNED</b> <u>2-5-66</u> <b>22d. ADDRESS</b> <u>WASHINGTON, D.C.</u>				<b>22e. REC'D BY REGISTRAR</b> <u>  </u> <b>22f. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Buried</u>				<b>23b. DATE THEREOF</b> <u>2/8/66</u>				<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Maplewood Cem.</u>			
<b>23d. LOCATION (City, town or county)</b> <u>Nelson, N.C.</u>				<b>(State)</b> <u>  </u>				<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Chung Chuan Tunkhono</u> <b>ADDRESS</b> <u>5101 King George Rd Washington</u>			

1855

CERTIFICATE OF DEATH

1855

State of New York, County of Westchester, City of New York.

I, the undersigned, a Justice of the Peace for the County of Westchester, do hereby certify that on the 1st day of January, 1855, at New York, in the County of Westchester, State of New York, died

John Doe, of the County of Westchester, State of New York, aged 45 years, of the following disease, to-wit:

Consumption of the Lungs, which disease he contracted at an early age.

He was buried on the 3rd day of January, 1855, at New York, in the County of Westchester, State of New York, at 10 o'clock in the forenoon.

Witness my hand and the seal of my office, this 1st day of January, 1855.

John Doe, Justice of the Peace.

Subscribed and sworn to before me this 1st day of January, 1855.

John Doe, Justice of the Peace.

Attest my hand and the seal of my office, this 1st day of January, 1855.

John Doe, Justice of the Peace.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and return them to the funeral director. Page 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Barnesville, Md 15-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Snagge</u> Last <u>Proctor</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>9</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 10, 1874</u>
9. AGE (In years last birthday) <u>91</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Spencer</u>		14. MOTHER'S MAIDEN NAME <u>Martha Stevenson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO <u>Mitral Regurgitation &amp; Myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>also Obstructive Jaundice from Hepatitis</u> DUE TO (c) <u>1 yr</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 min</u> <u>6 ys</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct-15-49</u> , 19 <u>49</u> , to <u>Feb 4</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Dec. 24</u> , 19 <u>65</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>J.M. Baxter</u>		22b. DATE SIGNED <u>Feb-10-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>J. M BAXTER MD</u>		22d. ADDRESS <u>Frederick.Md. 21701</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>2/13/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bells Chapel.</u>		23d. LOCATION (City, town or county) (State) <u>Dickerson, Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Surroden</u>		25a. REC'D BY REGISTRAR <u>FEB 14 1966</u>	
ADDRESS <u>Rockville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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THE UNITED STATES